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## BECKER'S

# Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

November/December 2010 • Vol. 2010 No. 6

## Top 10 Hospital Stories of 2010

By Leigh Page

**1. Healthcare reform.** A pitched political battle over passage of healthcare reform dominated the first quarter of 2010. Even after passage, Barack Obama and Democratic leaders have had to keep struggling for public acceptance. Rather than boosting Democrats' prospects in the November elections, the new law seems more likely to be a burden. Americans are still confused about what this sprawling legislation means for them and the law's individual mandate to buy health insurance is being met with stiff opposition.

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## 3 Best Practices for Bundled Pricing

By Lindsey Dunn

Healthcare reform has created an impetus for hospitals and other healthcare providers to work together to provide more efficient, higher quality care. These efforts are likely to take many forms, and the use of bundled payments specifically for acute-care episodes is almost certain to be among them as it is already being piloted by the Centers for Medicare & Medicaid Services. Bundled payments provide global payments rather than fee-for-service payments, typically for a certain episode of care, and most bundled payment programs allow for gain-sharing among providers of any savings created.

### CMS' current ACE demonstration project

In January 2009, CMS announced that five sites in Texas, Colorado, Oklahoma and New Mexico would take part in a three-year

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## Hospital Strategies and Transactions: Healthcare Reform and Market Evolution

By Jon O'Sullivan, Senior Principal and Founding Member, VMG Health

Hospitals and health systems are constantly refining their strategies based on changes in market dynamics. While these dynamics can include varying factors from changes in market competition to introduction of new medical technologies, perhaps nothing impacts the need for a hospital to reassess its market strategy more than changes in legislation. Importantly, while periodic changes in key legislation, including updates to federal Stark and Anti-kickback statutes, can dictate the scope and pace of strategy and transactions within a hospital system, the advent of major healthcare reform in the context of the recently passed Patient Protection and Affordable Care Act has started to and will continue to drive dramatic change in healthcare over the next two decades. Notwithstanding the impact to consumers, the effect of

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# Publisher's Letter

**Accountable Care Organizations – 8 Observations; Increased Integration Efforts; Increased Merger and Acquisition Efforts; Call for Speakers 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference, 2nd Annual Hospital Conference – Improving Profits, ACOs, Physician Hospital Integration and Key Specialties**

**C**urrently, there is a great deal of discussion relating to Accountable Care Organizations and physician hospital initiatives. The movement by some systems to embrace ACO-type efforts is accelerating catch-up efforts by other systems to compete with such systems including an increase in the acquisitions of practices by hospitals. The ACO efforts are also raising concerns regarding the long-term independent practice of medicine. On a separate note, we are seeing increased merger and acquisition activity in the ASC area, the physician-owned hospital industry and the dialysis industry. We are also seeing an increased number of healthcare industry qui tam/false claims cases.

This letter provides brief observations regarding the development of ACOs. The letter also includes a call for speakers and a note regarding signing up for E-Weeklies.

## ACOs

1. ACOs were established by the healthcare reform act to encourage greater coordination of care under Medicare. The concept is that different providers join together to coordinate care, share clinical information and report on quality measures and are financially rewarded for meeting

certain performance guidelines and cost-saving benchmarks. The intended result is that greater coordination will lead to improved quality of care, prevent costly hospital visits and ultimately produce a more cost-effective healthcare system.

While ACOs have been promoted as part of the healthcare reform act for Medicare patients, and pilot programs are being established, the real movement with ACOs seems to be with commercial payors at the moment. Further, the accelerated efforts by some systems to pursue ACO-type contracts is leading to a reaction by competing systems that are attempting to then accelerate the development of their own ACOs and integrated delivery systems. We are just starting to see very aggressive actions between integrated delivery systems and payors using the phraseology of ACOs to try and develop substantial steering of business by one system away from another.

2. Integrated delivery systems that control both the physician and the hospital side of care seem to be best situated to approach payors with ACO types of deals (in essence, deals that allow a system or ACO to share in savings below a base line as long as certain quality targets are met). Because an ACO needs to contract with a broad range of parties to be successful,

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an integrated delivery system that already includes a lot of the needed components will be able to get to market quicker. Because the ACO movement favors integrated delivery systems as a cornerstone piece of the effort, it is likely to cause a further acceleration of the acquisition of practices and employment of healthcare practitioners by hospitals and other health systems. ACO efforts will also put a new premium/value on primary care physicians who control patient populations. A key challenge in accelerating integration efforts relates to whether systems can aggregate resources/providers in a manner that makes sense in both a fee-for-service model and in a shared risk environment.

3. The ability to actually measure and control utilization depends on significant information systems, great nurse and physician leadership, tracking capabilities as well as having a good number of the medical coverage costs under control. To the extent an ACO has contracts with a great number of the providers that are necessary to provide healthcare services, the better it should be able to control costs. ACOs that truly invest in services and in infrastructure and provide a true value in managing costs will have a much greater likelihood of long-term success.

4. The political proposition in the healthcare reform act, as well as rhetoric from Washington D.C., tends to favor the development of ACOs over Medicare Advantage plans. The overall concept of pushing down responsibility for the entire cost of care is a very similar concept in Medicare Advantage plans as it is in ACOs. Thus, it is no surprise that organizations like Humana that were major players in the Medicare Advantage plan business are now examining ways to be in the ACO business with partners.

5. An ACO can be co-owned by multiple parties or it can be owned by one party. Moreover, an ACO can be developed by a wide range of healthcare provider groups from multispecialty physician groups to integrated physician hospital organizations. This flexibility extends into payment arrangements, which may take the form of the traditional fee-for-service with a percentage return on savings or a flat rate per patient, among others. Whether an ACO is managed by one party or co-owned by multiple parties, it will need contracts with providers that will allow for controlling costs, utilization and quality. Providers who contract with ACOs will be skeptical of the potential financial benefits to them and how closely these financial benefits relate to their own efforts. The ACO model may start to remind providers of the HMO and PPO withhold contracts of a decade ago.

6. There is no real proposition currently in healthcare reform as to single specialty ACOs. However, we will likely see significant developments around chronic high-cost diseases.

7. Where two competitive systems contract together to either form an ACO or offer services through an ACO (or an ACO includes both independent and employed physicians), there is a risk (reality) of sharing pricing information and/or a risk of price-fixing allegations. This risk is prompting the discussion of the need for an anti-trust exemption for ACOs. While the Association of Health Insurance Plans discourages an anti-trust exemption for ACOs, providers are pushing for such an exemption. Absent this exemption, many efforts will fall into an anti-trust gray area and further encourage complete consolidation and less competition.

8. The financial arrangements that are used in ACOs, such as shared savings, raise the possibility of impermissible payments under the Anti-Kickback Statute or the Stark Act. ACOs can attempt to structure their relationships to meet the personal services or fair-market-value exceptions or other exceptions under the Stark Act. However, these exceptions are often not a perfect fit for these financial arrangements. There is also not a simple ability to take advantage of safe-harbors under the Anti-Kickback Statute. The IDS model generally provides greater legal comfort from an anti-trust, Stark and Anti-Kickback perspective.

## Save the Date; Call for Speakers

1. 2nd Annual Becker's Hospital Review Improving Profits, ACOs, Physician Hospital Integration and Key Specialties Conference — May 19th & 20th, 2011. Scheduled keynotes include Chip Kahn, president of the Federation of American Hospitals, and Chuck Lauer, former editor of *Modern Healthcare*. Should you have a suggestion for a speaker or topic of if you have an interest in speaking, please e-mail me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

2. 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference — June 9th – 11th, 2011. Should you have a suggestion for a speaker or topic of if you have an interest in speaking, please e-mail me at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com).

3. 18th Annual Ambulatory Surgery Centers Conference – Improving Profitability and Business and Legal Issues – October 27th – 29th, 2011.

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**Top 10 Hospital Stories of 2010 (continued from page 1)**

*A stunning upset.* The Democrats' reform process began 2010 with good chances for success. The House and Senate had passed differing reform measures and just needed to hash out a compromise. But in January, the supposedly safe seat of the late Massachusetts Democratic Sen. Edward Kennedy, a staunch reform warhorse, went to Republican Scott Brown — an opponent of reform. Stripped of their 60-vote Senate majority against a Republican-led filibuster, Democrats had to push their reforms through using the controversial legislative tactic of reconciliation.

*Public distaste for insurers.* In the final month of debate, public distaste of the insurance industry was a key factor in winning over moderates. When Anthem Blue Cross proposed California rate increase in February of as much as 39 percent, President Obama used it to rally support for the beleaguered bill. Polls show the public roundly dislikes insurance practices such as denial of coverage due to preexisting conditions, which the reforms stop.

*Passage doesn't stop opposition.* When President Obama signed the Patient Protection and Affordable Care Act into law on March 23, opposition to the reforms did not fade away, as Democrats had predicted. About 20 states have filed lawsuits against the individual mandate and seven states are also suing to overturn the whole law as unconstitutional. Six months after passage, almost half of the public still has reservations about healthcare reform. The Kaiser Health Tracking Poll released in late August showed support for the new law dropped seven percentage points during that month to 43 percent, while opposition rose 10 points to 45 percent. It was the weakest showing for the law in Kaiser polls since May.

*The drive for repeal.* A big defeat for Democrats in the November elections would weaken President Obama's reform package. While President Obama would likely veto any attempt to repeal the law, if he were voted out of office in 2012, key pieces of the bill could be repealed before even being implemented. The individual mandate, the ban on denial of insurance due to preexisting conditions and expansion of coverage to 32 million more Americans are due to take effect in 2014.

**2. Integrating healthcare delivery.** Even if the healthcare reform law should fade away, its call for integrated healthcare would probably continue to be a powerful draw. It's worth noting that managed care rose out of the ashes of the failed Clinton healthcare reform bill in 1993 and revolutionized the industry. Even before the new reform law unveiled accountable care organizations, hospitals were moving toward something like it. Everyone has been looking for a way to achieve the efficiencies of HMOs in their 1990s heyday while still preserving quality and choice.

*Preparing for ACOs.* HHS' proposed rules on ACOs are due at the end of the year, and payments to ACOs will start Jan. 1, 2012. Meanwhile, private insurers such as Blue Cross Blue Shield of Massachusetts are implementing similar payment strategies in small programs or pilots. The private-based groundswell for ACOs suggests this approach will rise even if the healthcare reform law is repealed. The hope is that coordination of care can slow down double-digit yearly rises in healthcare costs. Those who don't join ACOs will face other forces pushing them in the same direction, such as disincentives for readmissions, use of bundled payments and medical homes and reduced hospital reimbursements.

*Learning from HMOs' mistakes.* ACOs are said to be the next step in managed care, minus all the problems that brought down capitated arrangements



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in the late 1990s. Like HMOs, ACOs still focus on primary care but they have gotten rid of the bossy “gatekeeper,” whose approval was needed to see a specialist. And while capitation ended up bankrupting many providers, ACOs offer a financial safety net by paying providers fee-for-service payments plus bonus payments for savings they realize. Also, ACOs place a greater emphasis on quality than capitation ever did and, to boost effectiveness, rely heavily on healthcare IT, which was still in its infancy in the 1990s.

*Hospitals buy up practices.* In preparation for ACOs and other integrated approaches, hospitals have been eagerly buying up physician practices. The medical profession has been glad to help. A new generation of physicians prefers employment status and lots of their older colleagues are running to hospitals for cover from falling reimbursements and the bad economy. Cardiology groups in particular are moving fast to employed status. In the past, hospitals focused on buying primary care physicians, but now they are also particularly interested in cardiac surgeons, orthopedic surgeons, general surgeons and neurosurgeons.

**3. RACS get rolling.** Medicare’s four regional recovery audit contractors started their work in 2009 with automated reviews not requiring hospitals to submit medical records. In the first quarter of 2010, RACs denied a total of \$2.47 million in Medicare claims, according to the AHA’s RACTrac Survey of 653 hospitals. Even though RACs are limited to requesting no more than 200 records every 45 days, the volume of requests could put a strain on hospitals. Every request requires clinical notes, completed forms, bills, lab results and other documents be pulled and reviewed.

*Audits beaten up this summer.* This summer, RACs were allowed to begin performing medical necessity audits, which accounted for 40 percent of all improper payments identified in the three-year RAC demonstration project. Such audits can erase much of the payment for an admission, leaving behind only some billing for Part B ancillary services. In early August, the CMS New Issue Review Board approved RAC audits for 18 types of inpatient hospital claims and one type of durable medical equipment claim. By the end of August, contractors in regions B, C and D had issued lists of claims for medical necessity reviews.

*Scrutiny moving beyond Medicare.* In 2011, RACs will move beyond Medicare in an expansion ordered by the healthcare reform law. Medicaid, Medicare Part C (Medicare Advantage plans) and Medicare Part D (prescription drug plans) have to employ RACs by Dec. 31, 2010. Under the Medicaid RAC program, each state Medicaid agency is required to contract with a contractor in programs that will be separate from the current Medicaid integrity programs.

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**4. For-profits buy up hospitals.** It is no accident that the two biggest healthcare purchases this year were announced within a few days of signing the healthcare reform law. And it is no surprise that both of the buyers were for-profit, investor-owned organizations with easy access to capital. Vanguard Health Systems announced plans to buy eight-hospital Detroit Medical Center, Michigan’s largest healthcare system, for \$1.4 billion while Cerberus Capital Management, a New York private equity firm, bid for Caritas Christi Health Care, a six-hospital system in the Boston area, for \$830 million. Analysts noted the reform law, with its expanded healthcare coverage, made these two struggling systems, each with a high percentage of uninsured patients, attractive acquisitions for private investors.

*Hospital sales on the rebound.* Hospital acquisitions, which had been in the doldrums for a few years, are perking up. Avondale Partners reports the value of hospital acquisitions, based on revenues, was about \$2.4 billion last year, but this year acquisitions are shaping up to total more than \$6 billion. Sellers have been bringing down their asking price 0.9 times annual revenues in 2007-2008 to about 0.5-0.6 times revenues in sales this year, Avondale reports. These hospitals are hungry for capital to keep them competitive, but loans with reasonable rates are much harder to get in the recession. Add these changes to the healthcare reform law, which “moved sellers off the fence by providing some clarity about the future landscape,” according to Kemp Dolliver at Avondale. Mr. Dolliver predicts for-profits have enough pent up demand for this upsurge in activity to last a couple of years.

**5. Ban on physician-owned hospitals.** The twists and turns in the passage of healthcare reform in the first quarter of 2010 were an emotional roller coaster for physician-owned hospitals. If the reforms had failed, which seemed quite likely at a few points, the sector would have been saved, but the final law is quite brutal. It bars existing facilities from expanding and new facilities from opening. Some 260 existing facilities cannot add ORs or patients beds or increase the percentage of physician ownership. New projects had to step up the pace of construction or close down. Industry lobbyists did manage to push back a ban on new construction from a retroactive date in the House bill to the end of 2010. But the damage is quite extensive. Two months after the law was passed, ongoing construction on 27 new physician-owned hospitals had stopped.

*Alternatives discussed.* Planners also began discussing alternative ways to open physician-owned hospitals. These included switching to a non-profit foundation, selling to non-physician investors, allowing physicians to operate under a management agreement and allowing them to own the real estate and not the hospital. Some even considered serving just private payors and self-pay patients, thus avoiding the threat of losing Medicare and Medicaid reimbursements if they opened.

**6. Physician fee cuts.** Congress’ automatic cuts in Medicare physician fees, set 13 years ago, came home to roost in 2010, as the House and Senate blundered through three short-term fee fixes, reimbursements were postponed and many physicians had to lost faith in Medicare. Congress had temporarily delayed the cuts every year since 1997, but amount of the cut continued to accumulate, so that by 2010 it added up to more than 21.3 percent.

*Deal with AMA goes sour.* In negotiations for the healthcare reform law in late 2009, Congressional Democrats apparently assured the AMA the automatic fee cuts would be permanently abolished. However, since abolishment would cost a whopping \$250 billion in lost revenue — on paper, at least — and Democrats wanted a revenue-neutral bill, the fee fix was removed from healthcare reform. The House passed a separate fee fix. Senate Democrats removed a modest one-year fee-fix from their reform bill but never passed a separate fee fix due to the cost.

*Constant state of crisis.* Over the first half of the year, the threat of Medicare fee cuts created an almost constant state of crisis. In late Dec. 2009, with a permanent fee fix still out of reach and just days to go before Congress’ 2008 fee fix was to expire, House and Senate passed a shorter two-month fee fix in hopes of hashing out a permanent solution in that time. But as

the March 1 onset of a new fee cut loomed and Congress still hadn't passed healthcare reform, it stalled for time and passed a one-month fee fix. The fix came a few days late, forcing CMS to freeze payments. CMS had to do this again on April 1, but this time the freeze lasted for 15 days before Congress passed yet another temporary extension, this time for two months.

*Fixes delayed longer.* In mid-May, House and Senate leaders discussed legislation to provide stable Medicare updates through 2014, but the idea was withdrawn when they couldn't find the votes. When the temporary fix ended on June 1, Congress was totally unprepared to act. This time CMS could not hold back payments long enough and actually had to start paying claims with the 21.3 percent cut on June 17. A week later, Senate and House finally passed a six-month fee fix that postponed the problem until after the November elections. The cut was replaced with a 2.2 percent increase.

*Impact on physicians.* Some practices dependent on Medicare had to take out loans to cover the delay in reimbursements and some physicians began pulling back from Medicare. The AMA reported 17 percent of surveyed physicians said they would restrict the number of Medicare patients in their practice. The current fee fix runs out at the end of November, after the elections. How long the next fee fix will last is anybody's guess.

**7. Hospital quality reporting.** This year hospitals are reporting 46 quality measures involving process of care, clinical outcomes and patient satisfaction. CMS reports 99 percent of hospitals participated in the reporting program and 97 percent received compliance bonuses as of 2009. In July, CMS expanded its Hospital Compare website to include new measures related to outpatient care. The website, which provides selected information reported by each hospital, debuted five years ago. In April, CMS announced plans to introduce financial penalties and add 10 more measures.

*Future plans.* CMS will cut payments to hospitals with high readmission rates as of Oct. 2012 and cut pay by 1 percent to hospitals with the highest rates of healthcare-associated conditions starting Oct. 2014. In addition, the new Center for Medicare and Medicaid Innovation will experiment with different care payment mechanisms to tackle priorities such as reducing readmissions and improving chronic care management. Meanwhile, the reform law has big plans for quality reporting. Beginning in 2012, payments to hospitals will be based on their scores rather than on simply reporting results. And in 2015, CMS will start reporting each hospital's scores and reduce payments by 1 percent to hospitals with the highest rate of medical errors and infections.

**8. The war against healthcare fraud.** The federal government has been beefing up operations to combat Medicare and Medicaid false claims and fraud by healthcare providers in the past two years. In May 2009 the Justice Department and HHS announced the creation of the Health Care Fraud Prevention and Enforcement Action Team. In Aug. 2010, the Labor Department had increased its staff of wage-and-hour investigators by one-third to investigate pay practices throughout the healthcare industry, following the revelation that many hospitals do not pay sufficient overtime.

*Reform law adds to push.* The healthcare reform law provides \$300 million in funding for fraud investigation and enforcement by over the next 10 years. Some states also got involved in the investigating. North Carolina expects to recover tens of millions dollars a year in fraudulent Medicaid claims by hiring a contractor to sift through electronic submissions.

**9. Big boost for healthcare IT.** No one seems to disagree that healthcare IT, especially installation of an electronic medical record, reduces errors and makes hospitals more efficient. But many hospitals and practices still shy away from IT because it is costly and can be disruptive, and federal guidelines have turned out to be daunting. Even the prospect of generous federal incentive payments has not brought most hospitals and practices from the sidelines.

*Incentive payments.* Beginning in 2011 and lasting for the next six years, the

federal government will offer \$34 billion in incentives for healthcare IT to hospitals and practices, but not to ASCs and other healthcare facilities. Healthcare IT systems will have to conform with "meaningful use" criteria. The original proposed standards for meaningful use, released at the end of 2009, proved to be so demanding that even many IT-savvy institutions, like Partners HealthCare, Kaiser Permanente and Intermountain Healthcare, said they would be hard to meet. With its final "meaningful use" criteria, released this August, HHS has relented somewhat, allowing more time for providers to phase in the guidelines.

*A long way to go.* Studies have shown the vast majority of hospitals and practices haven't even started the process. For example, a study this August in Health Affairs found the number of hospitals that had adopted an EHR system rose only slightly from 8.7 percent to 11.9 percent from 2008 to 2009, and only 2 percent of the hospitals had IT systems that would to meet meaningful use criteria.

**10. Don Berwick arrives at CMS.** Donald Berwick, MD, was nominated to head CMS in April but never went through confirmation hearings and finally took office on July 6 as a recess appointment. As former president and CEO of the Institute for Healthcare Improvement, Dr. Berwick holds an enormous amount of good will within the hospital community. Virtually all the national hospital organizations endorsed his nomination. But his controversial statements on rationing healthcare and his past enthusiasm for Britain's nationalized healthcare system also make him a controversial figure.

*The face of reform.* Dr. Berwick, with his career-long emphasis on process improvement and thinking up new ways of healthcare delivery, is a strong promoter of the healthcare reform law. He has declined media interview requests and has kept a low public profile, but he is said to be reveling in his new job. He has been personally involved in writing proposed regulations on accountable care organizations and picking test sites for new healthcare strategies. "This agency has just won my heart," he said in a CMS video.

*Appointment ends before 2012.* Dr. Berwick's recess appointment expires at the end of 2011. Unless he can win over some GOP senators who oppose him, he won't be able to win a 60-vote confirmation in the Senate and would be forced to leave office. Dr. Berwick recently rebuffed a request from Iowa Senator Chuck Grassley, the ranking Senate Finance Committee Republican, for a list of Institute for Healthcare Improvement's large financial donors. Sen. Grassley said the lack of a confirmation hearing has prevented the public from learning of Berwick's potential conflicts of interest. ■

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### 3 Best Practices for Bundled Pricing

(continued from page 1)

Acute Care Episode demonstration project on the use of bundled payments for certain cardiovascular and orthopedic procedures. Under the demonstration, CMS will pay the hospitals a lump sum for all Part A and Part B services, including physician services, pertaining to the inpatient stay for Medicare fee-for-service beneficiaries. The hospital, then, is responsible for compensating the physicians and any other providers for their services.

The pilot intends to help CMS bend the cost curve by targeting some of the highest cost procedures and giving providers financial incentives to become more efficient, says Robert Minkin, a senior vice president with healthcare consulting firm The Camden Group, and formerly CEO of Exempla Saint Joseph Hospital in Denver when it was selected to participate in the ACE project.

### PPACA's five-year pilot

The Patient Protection and Affordable Care Act created a five-year Medicare pilot to test bundled payments for a wider array of services than the current pilot. This demonstration will cover acute-care and post-acute care services, including such services as rehab and physician office visits, for certain medical episodes and is scheduled to begin in Jan. 2013. As with the current pilot, providers must bid to participate, offering Medicare a certain percentage discount off of fee-for-service pricing. As such, hospitals that bid for the demonstration project must be cautious in evaluating the financial risk such relationships create.

### Bundled payments with insurers

While CMS isn't expected to roll out bundled pricing more widely until at least after 2018 — and that's assuming the pilots are successful — many hospitals across the country are already entering into bundled payment agreements with commercial insurers. As hospitals enter into these relationships, they should consider the following three issues in order to ensure the rewards of such an arrangement outweigh the risks.

#### 1. Move toward integrated delivery.

Many of the savings created in the current ACE demonstration project come from improving efficiency and standardizing care, but hospitals taking part in the second pilot will need to oversee care coordination among several outpatient providers in order to be successful.

Shannon Fiser, vice president of financial operations for Ardent Health Services, which has two systems in the current ACE pilot — Hillcrest Medical Center in Tulsa, Okla., and Lovelace Health System in Albuquerque, N.M. — says Hillcrest achieved cost reductions pri-

marily by working with physicians to standardize devices and reduce surgical supply costs. The ACE project allows Hillcrest to share the savings with the physicians, thereby incenting them to continue working with the hospital to further reduce costs.

However, process improvement within hospitals can only go so far. Eventually the processes will reach a breaking point of efficiency where no more costs can be derived. After this, the only savings that can be created will come from better coordinating care across multiple providers and sites — an issue the second demonstration project addresses. In order to be successful in coordinating care, hospitals will need to develop or join systems that allow for the integrated delivery of care.

“Hospitals have detailed data on their costs and can often confidently provide a technical fee discount to payor,” says Mr. Fiser. However, many hospitals don't know the costs for outpatient components of care. Unless a hospital is a part of an integrated system, it may have difficulty comparing the true costs of physician and other outpatient services against standard reimbursements, thereby making it very challenging to offer a bid that includes an appropriate level of risk. Hospitals that are part of integrated systems have a deeper knowledge of non-hospital-based costs and greater opportunity to create savings through coordinating care.

Integrating care also moves hospitals toward being an accountable care organization, for which the PPACA also created a Medicare pilot. Mr. Minkin calls ACOs “the end state for what national health reform anticipated.” He adds, “ACOs move these relationships from smaller scale ideas like bundling payment for a single cardiac or orthopedic episode to an arrangement that holds providers accountable for managing the care of an entire population.” ACOs are expected to take different permutations, but essentially build on the idea that care must be more tightly coordinated. Providers that position themselves in away that allow them to coordinate care, will be most poised for success under this model as well.

#### 2. Actively take on the role of a payor.

Most healthcare providers are not currently set up to take on the role of a payor, both in terms of human and healthcare information technology resources, says Mr. Minkin. In order to be successful under a bundled payment system, hospital must be able to assess risk, set appropriate prices given those risks and pay out claims to the various providers offering their services as part of the bundled payment.

“Becoming a claims administrator is the biggest operational issue to address,” says Mr. Fiser. Hillcrest contracted with a third-party software provider to develop a program that allows the hospital to handle claims and communicate claims information to physicians. “Because of the small

number of claims that fall under the bundled contract we have been able to do it ourselves, but if it became a broader concept, we would have to look at a higher-end contract [with a third-party],” he says.

Hillcrest's claims process works like this: Hillcrest submits the technical portion of a claim to its fiscal intermediary, and the physician does the same for the professional fee. Hillcrest's software is then able to “grab” the physician's claim from the fiscal intermediary and calculate the payment rate to the physician, says Mr. Fiser. Because of its unique claims process, Mr. Fiser says the hospital has experienced a greater slow down in receivables payments than anticipated, which other hospitals should take note of.

### 3. Ensure physicians' and other providers' incentives align with desired outcomes.

Finally, in order to ensure physicians — who drive the majority of health costs — are actively engaged in taking costs out of healthcare delivery, hospitals must align financial incentives for physicians with the desired outcomes of the bundled arrangement. Often, this means physicians are rewarded for following specific protocol for providing care. For example, Hillcrest physicians receive a bonus of up to 25 percent of their fee-for-service reimbursement rates if they follow clinical protocol in 98 percent of their cases.

Mr. Minkin says financial incentives even at the 25 percent mark can be powerful given the increasing downward pressure on Medicare physician fees. Although not as direct as an incentive payment, Exempla Saint Joseph further encourages physician participation by paying claims to physicians within 15 days, while the average length before receiving a Medicare payment is 45 days. “Paying our participating physicians more quickly is another form of incentive to further reinforce that these changes are good for them as well,” he says.

Keep in mind, however, that hospitals should be cautious in any financial arrangement with physicians. While the current Medicare ACE pilot provides legal exemptions for incentive payments and it is expected other pilots will do the same, hospitals must still ensure their incentives payment are not based on the volume or value of a physician's referrals.

### Looking ahead

While many Medicare and commercial bundled payment programs are just in their infancy, the emphasis healthcare reform places on coordinating care to draw out costs is expected to only increase the prevalence of these and similar arrangements. Hospitals that begin to develop structures and processes to allow for bundled agreements will be better positioned for success in light of reform than those that do not. ■

**Hospital Strategies and Transactions: Healthcare Reform and Market Evolution (continued from page 1)**

healthcare reform will drive strategy and transactions that impact hospital structures, physician practices, ancillary services and the relationships between physicians and hospitals.

**What hospital leaders are thinking about**

Hospital leaders are confronted with a dizzying amount of challenges that may be overcome in the context of a strategy that will best position their organization for success over the long term. Unfortunately, many, if not most, of those challenges and the approaches to overcome them are ill-defined. Some examples of these include the following:

**Patient Protection and Affordable Care Act.** This piece of legislation has been rightly characterized as a major milestone for legislators and has been hailed as the most significant piece of legislation in a generation. However, for most hospital leaders, it represents a very broad and poorly understood challenge. Realistically, aside from general statements regarding numbers of new enrollees in government sponsored programs, there is little to guide hospital leaders to understand what changes should be made to strategic and business plans to meet the challenges of the future.

**32 Million Medicaid enrollees.** At its core, healthcare offers the promise of health insurance coverage for a vast number of the currently uninsured population. How, when and where this mass of people will receive care and its impact on hospital strategic imperatives is a question placed squarely on the desk of hospital leaders.

**Accountable care organizations.** ACOs offer a theoretical framework for increasing quality while reducing costs. They are theoretical because outside of a few new pilot projects, none has been implemented. Moreover, while most hospital leaders understand (and thus embrace) the concepts of improving quality and reducing costs, few have any real understanding of the new organizational structures, relationships, mechanisms and metrics that are supposed to characterize an ACO.

**Bundled payments and episode-based payments.** The prospect of changes in reimbursement structure is perhaps one of the most significant topics on the minds of hospital leaders. How hospital organizations will adjust and perhaps even take advantage of these changes is being scrutinized by almost every hospital CEO. Importantly, these payment mechanisms are credited with significant reductions in cardiac procedures based on pilot programs conducted several years ago. However, while a few payors are currently conducting additional pilot programs for orthopedic care, they are far from implementation on a broader scale.

**Measuring quality.** As a component of healthcare reform, hospitals are continuously being told by healthcare experts and pundits that they must institute quality measurement systems, and align physician interaction and behavior to improve quality.

**Shortage of 150,000 primary care physicians by 2025.** Several national studies have indicated a significant shortage of physicians over the next 10-15 years. Given the direct relationship between the physician and patient, and the referral relationship between physicians and hospitals, the prospect that the hospital with the most physicians will win (and the risk that their hospital will not have those physician relationships) puts many hospital leaders in a challenging position.

The responses to these and other vexing issues by hospital leaders are as varied as the issues themselves. However, one common element seems to be the imperative to start doing something. As a result a wide variety of transactions are currently being conducted in an unparalleled effort to prepare for the future. Unfortunately, although many transactions have a stated purpose of getting prepared for the aforementioned challenges, how they fit into a well thought out business strategy is often a missing component. The responses include the following:

**Develop an integrated delivery network.** Much like the mantra of the 1990's when physician hospital organizations and gatekeeper models were in vogue, the IDN has once again become the elixir for meeting the challenges of the future.

**Acquire physician practices.** While many hospitals learned painful lessons relating to the acquisition and management of physician practices, either the hangover of those experiences has faded or there is a belief that current market factors are different. In any case, while the drumbeat of physician practice acquisition has become louder, more hospitals are viewing practice acquisitions as part of the solution to meeting new challenges.

**Acquire ancillary services.** Over the last 20 years, hospitals have been in the unenviable position of watching outpatient service lines moved out of their provider entities by entrepreneurs and participating physicians. Some were captured within the physician practice under Stark exceptions and others were stripped away from hospitals into outpatient ventures. Now with significant cuts in reimbursement (imaging) or more limited ability to obtain out-of-network reimbursement (surgery centers), hospitals have an increased opportunity to reacquire those services into their provider entities and enhance their opportunity to once again envision an IDN.

**Structure quality measures.** Almost any objective to measure and improve quality metrics within a hospital requires the active participation of physicians, especially those with direct involvement with the service line in question. A number of factors have improved the opportunity for hospitals to structure quality measures with physicians. These include more defined financial incentive structures, greater realization on the part of physicians for the need to align

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with hospitals and higher risk of ventures outside the hospital. For hospitals, the opportunity to preserve services and revenues under the provider umbrella while creating an alignment with physicians is not only a welcome market change, but also fits with perceived strategic needs.

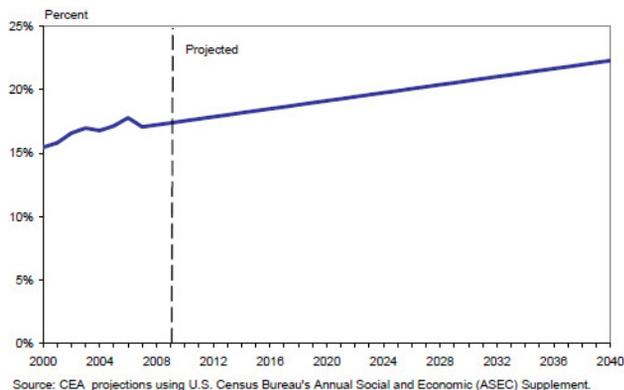
**Hospital acquisitions.** As the prospective impact of more realistic financial scenarios associated with healthcare reform become evident, many hospital leaders recognize that smaller or weaker hospitals will not survive the economic fallout. While this is sad news for small or independent community hospitals, it represents an opportunity for many health systems to expand their reach through market acquisition. The potential added benefit is more negotiating leverage with payors.

### Progression of change

Amidst the backdrop of challenges being presented to hospital leaders are questions regarding how the proposed reform of healthcare will actually unfold. A significant part of this question is rooted in the ever changing estimates of cost. Two tables illustrate the precarious nature of the current expectations regarding the affordability of current legislated healthcare reform.

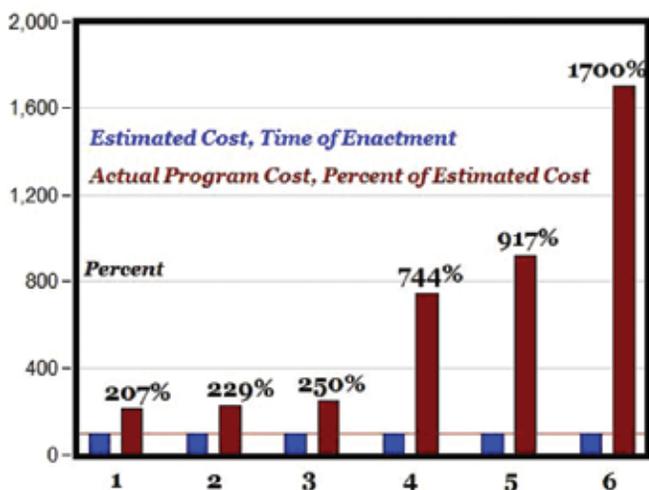
The first demonstrates that total healthcare spending is projected to grow from 16 percent of GDP (\$2.5 trillion) in 2009 to 25 percent of GDP (\$4.5 trillion) by 2025.

### National Health Expenditures as a Share of GDP, 1980-2040



The second table illustrates the ability of federal budgeters to effectively estimate program costs at the time of enactment.

### Actual Costs vs. Estimated Costs Various Medicare Programs



PROGRAM
1. Medicare Catastrophic
2. Medicare End-Stage Renal Disease (ESRD)
3. Medicare Home Care
4. Medicare Hospital Insurance
5. Medicare (Entire Program)
6. Medicare Disproportionate Share Hospital (DSH)

Source: Joint Economic Committee

The logical conclusions that one can reasonably draw from these two tables (as well as other evidence) would be: 1) healthcare reform as currently envisioned is not economically viable; 2) current cost estimates could be wildly optimistic; and 3) healthcare reform is far from over and the unforeseen changes will be dramatic relative to the current healthcare environment.

While the ultimate impact of healthcare reform is difficult to imagine, one can draw some realistic conclusions relating to various components of the market. These include the following:

**Conclusion 1:** Current estimated levels of future healthcare spending are not sustainable. At a level of 25 percent of GDP, one in every four dollars would be spent on healthcare and that is only if current estimates are correct.

**Result:** Significant restructuring will occur in the healthcare market. These will include cuts in reimbursement, changes in payment structures and other reforms that will slow the rate of spending

**Conclusion 2:** Physicians across a variety of specialties will struggle. Similar to recent cuts in cardiology reimbursement, other physician specialties will certainly face fee cuts in both professional and ancillary services.

**Result:** Similar to the effect on cardiology practices, physicians will seek the security of hospital systems that can purchase their practice and employ the physician at a compensation level that reserves their level of income.

**Conclusion 3:** Ultimately, as a result of the imperative to decrease spending, largely through either direct cuts in hospital fees or changes in payment structures that yield the same economic effect, an estimated 20-25 percent of hospitals (approximately 1,000) will fail.

**Result:** As hospital reimbursement is decreased, or the impact of changing reimbursement model that are designed to cut costs go into effect, many hospitals that currently struggle with low margins will be unable to survive independently. As a result, most of these hospitals will either be acquired by healthier hospital systems, converted into specialty facilities or be closed.

**Conclusion 4:** As stated above, the estimated level of future healthcare spending is not sustainable. As a result, one can only conclude that significant additional changes will be required to maintain a solvent Medicare system. These changes may, among other things, include changes in enrollment age, eligibility based on income or asset testing and limitations on access for certain medical conditions.

**Result:** Over time, as more affluent baby boomers are ineligible for participation in a government-funded program, or the level of access and care in the program is decreased, other public/private or private models will evolve to provide desired levels of service. This could ultimately evolve into a two-tiered healthcare system.

### Characteristics of a two-tiered healthcare system

While the evolution towards a two-tiered healthcare system similar to that of the United Kingdom is a hotly debated issue, based on current trends in the market, it is certainly a possibility. Additionally, those same trends might provide some insight as to some of the characteristics of a public system as compared to a public/private or private system.

## Public healthcare

- Non-Profit (or, more accurately, tax-exempt) hospitals will be required to participate in federally sponsored healthcare programs (Medicare and Medicaid). These hospitals will have to determine how to restructure to serve the estimated 32 million additional enrollees and how to operate under new reimbursement systems
- Given the unsustainable prospective increases in healthcare spending, and the inevitable level of payment cuts, public hospitals will have to operate as high volume, low margin deliverers of service. They will be forced to adopt a 'Walmart' perspective.
- As competitive and financial pressures grow, a significant number of public hospitals will struggle to offer new delivery models (ACOs, bundled payments, episode-based payments) for government plans. These 'at risk' hospitals will wither, be acquired or, in the most extreme cases, require direct government support.
- As hospitals seek to determine how to serve a growing publicly insured population, and seek to control and manage a more limited pool of available dollars, larger public hospitals will accelerate the employment of physicians into their networks. These physicians will see the opportunity for employment by hospitals as a way to maintain their economic security in the face of reimbursement cuts and limitation on the ability to provide ancillary services.
- Physicians employed by public healthcare systems, largely as a function of physician practice acquisitions, will be required to provide services to all patients for whom the healthcare system provides services.
- Ultimately, as physician reimbursement decreases, or hospitals fail to effectively manage the financial aspect of physician practices, compensation for employed physicians will decrease.

## Public/private or private healthcare

- Private healthcare will evolve in different ways in various parts of the healthcare landscape. In most cases, private healthcare will be offered along specific services including inpatient and outpatient surgery, cancer care, women's services and other areas.
- Specialty providers of private healthcare will ultimately consolidate to be able to offer either regional or national scope to patients and private healthcare insurers.
- Public healthcare systems will recognize the need to offer separate services to affluent consumers in order to maintain higher margins associated with consumer health plans that offer wider access.
- Physicians in private practice will either participate in both public and private healthcare, or, in some cases, opt out of participation in public plans and focus exclusively on private healthcare.

While the specific evolutionary path of the healthcare market is far from clear, what is clear is that the healthcare environment will go through dramatic changes. The current level of projected spending is not sustainable, and the only realistic outcome is a restructuring of the market that will yield lower spending growth though decrease utilization and lower costs. While healthcare reform is intended to accelerate mechanisms that will yield improved outcomes, the process will entail a myriad different strategies that will drive transactions that impact hospital structures, physician practices, ancillary services and the relationships between physicians and hospitals. As in many sectors of the domestic economy, market dynamics, financial opportunities and consumer needs will play a part in the evolution of healthcare. Only time will tell which of these strategies and resultant transactions will yield their intended results. ■

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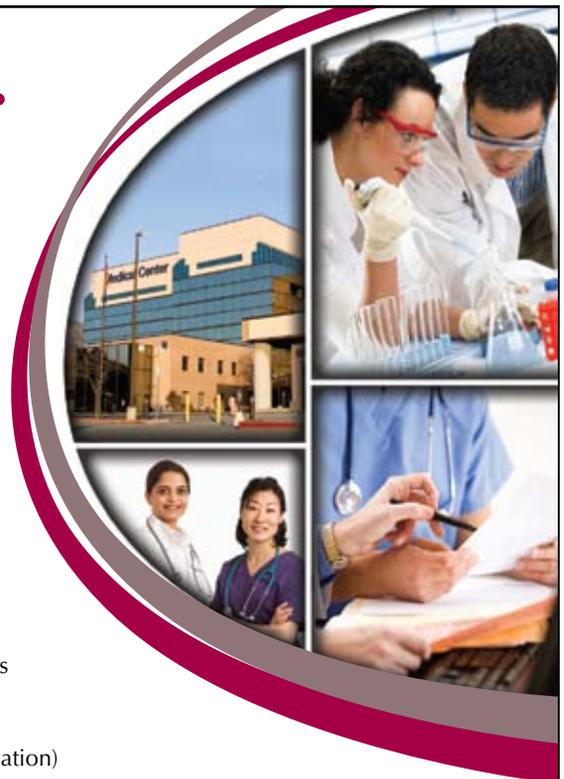


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# The Implementation of New Models of Care: Q&A With Iowa Health System CEO Bill Leaver

By Rachel Fields

**A**s hospitals and health systems prepare for changes brought on by healthcare reform, these providers are examining how they can approach and build new models of care, whether they involve ACOs, bundled payments or medical homes. Here, Bill Leaver, president and CEO of Iowa Health System, answers questions about the future of fee-for-service, the move toward “coordinated care” models and the importance of EMR and physician integration to future delivery models.

**Q: Medicare will introduce a pilot program for ACOs in 2012, and in the future, hospitals will likely be compensated based on a pay-for-performance model rather than a fee-for-service model. What is the future of fee-for-service payment models?**

**Bill Leaver:** We fundamentally believe fee-for-service, as we know it today, will be dead. The only question is when the obituary will be written. It's not a sustainable model, and we have believed that for quite some time. The focus in reform is about transitioning away from fee-for-service to a value-based system, but the question is how do you quantify and define value, and what's the appropriate payment model for that?

You see the reform legislation [proposing] a variety of different models. ACOs are the most prominent and are getting a lot of media coverage, as well as bundled payments where you're paying for an episode of treatment. All of that is now being defined, and we are supportive of moving away from fee-for-service, which is very fragmented and rewards quantity or volume over quality.

All of that is now being defined, and there are certainly efforts around writing rules on how this will be implemented. We are supportive of moving away from fee-for-service, which is very fragmented, episodic, and rewards quantity or volume over quality.

**Q: How is Iowa Health System moving toward new models of care that reward quality rather than quantity?**

**BL:** We are focused on how we take responsibility for coordinating patient care, particularly for chronically ill patients. Care coordination for the chronically ill will be the focus of most ACOs and bundled payments. Our efforts are in creating the clinical infrastructure and making sure IT systems allow us to do that, as well as aligning our efforts with physicians, whether they're employed or independent.

For some time, we have been creating what we would characterize as an advanced medical care team that would complement the medical home by providing care for the most severe chronically ill patients. Many people with a chronic disease have several chronic diseases. Can the primary care physician have the resources and time to effectively coordinate care for that severely chronically diseased patient? To provide more resources, we are creating a complementary service in this advanced medical team to help the primary physician in that medical home.

**Q: You talked about making sure IT systems help providers care for chronically ill patients. Going forward, how can EMR be used effectively to promote the continuum of care?**

**BL:** The question going forward is, “How do we get these disparate clinical systems to talk to one another, and how do we create interoperability between them so that information about the patient is in front of the clinician when you need to make a clinical decision?” Under an ACO model or a new delivery model, you need the ability to provide real-time information about the movement of the patient through the system. For example, the primary care physician should be aware of what is happening to the patient and what the patient needs in terms of intervention.

That will be a challenge because currently, our IT systems have a way to go in terms of creating that real-time picture. If we have somebody who is seeing one of our primary care physicians, and the patient hypothetically has a back problem and decides on their own to visit an orthopedic surgeon, our current systems wouldn't necessarily alert the primary care physician that the patient has gone to an orthopedic surgeon. It's not clear whether the orthopedic surgeon would know the patient had seen a primary care physician in another setting. When we talk about coordination of care, that's really going to be about how to keep information within the system so the appropriate clinicians know where the patient is.

**Q: Are those changes the responsibility of IT vendors or health systems at this point?**

**BL:** It's a little bit of both. The Obama administration has made a fully functioning EMR a priority as a matter of national policy, and we have been working closely with the state and other big health systems around the creation of health information exchange that would allow for the transfer-



Leaver

ence of clinical information across systems. It's not vendor dependent, but it is an obligation of the vendor to make sure they're connected to the Health Information Exchange and that interoperability is present. I think most vendors see where the future is going to be, so I think it's a matter of creating the right safeguards on patient confidentiality and privacy and establishing the means for the transition of that information.

**Q: Large health systems and academic medical centers seem to have certain financial advantages in implementing the medical home model. Will community hospitals be able to participate as well?**

**BL:** I don't know that we would conclude that the community hospitals wouldn't and couldn't have a role in the medical home. It requires some investment in infrastructure to create a medical home, and we have a good idea of what that investment is. It has to be about the community hospital's willingness to invest, because physicians are not going to have all the resources to make that investment. Some rural hospitals have moved forward in a pretty progressive way with their primary care physicians to create a different model of care.

The community hospital has to recognize that perhaps with the creation of medical homes and different models, they may actually see less business. From a national policy perspective, we're not going to get rewarded for readmissions, and we're going to see fewer visits to our emergency departments. Community hospitals can make a new model work, but they're going to have to realize the old business model is not going to suffice going forward. They're going to have to get used to seeing patients in different settings and being rewarded differently. But I think community hospitals, given the right leadership, can certainly make that work.

**Q: Could you identify mistakes health systems might be making now that will impede their involvement in new care models in the future?**

**BL:** Culture will become very, very important to organizations that want to survive and thrive in the future. Organizations that have the right culture and the right interests will be the ones that are successful. If hospitals are not making investments in critical clinical infrastructure, their ability to avoid readmissions and take advantage of opportunities in the reform law will be lost.

Secondly, some organizations have said they're going to employ all physicians, but if you don't employ the right ones or enough in a sufficient quantity, you can create management headaches or significant losses. You could create a backlash within the medical community that would be hard to overcome. I think it's also critical that large organizations are investing in IT now.

**Q: In April, you talked to *The Des Moines Register* about keeping chronically ill patients out of the hospital by using home health nurses and in-home monitoring units. Where is that project now?**

**BL:** Our project, in terms of integration of home health care and in-home monitoring, continues to progress. We're deploying that in three regions right now, and we're still in the beginning stages, but we're seeing some early success in that. The whole focus is on reducing readmissions and emergency visits. We're making good progress in that regard. I think that the development of the medical home, the coordination of care and the integration of home care are all fundamental to being able to reduce the cost of chronic disease and treating chronic disease. We spend 50 percent of our money on treatment of chronic disease, and we need to lower that cost.

In addition, we want to get paid to do that, so we want to demonstrate value by saying, "Here's what we did in terms of reduction of cost" so the government or commercial insurance company pays us for it. That

will help us replace some of that revenue. It won't necessarily be a dollar-for-dollar replacement, but we want [improving quality] to be financially manageable and take care of the business.

**Q: How is Iowa situated to handle the influx of newly insured patients and the predicted shortage of providers? How will that affect the hospitals in Iowa Health System, particularly those that work with rural Iowa hospitals?**

**BL:** There's certainly a lot of uncertainty and a lot of unknowns, but we need to recognize that in some ways, the system has been treating these uninsured patients already. The question is, have we been treating them in the most appropriate setting? If we can effectively put the now-uninsured, soon-to-be-insured patients into a primary care setting, we should. In Iowa, we have enough primary care physicians if we restructure their office and use more mid-level providers.

**Q: What are the biggest opportunities for hospitals right now?**

**BL:** The biggest opportunity is really to transform the delivery system to manage the patient population and create a better experience for both patient and physician. Physicians want a system that's more responsive to their needs, and more rapid in response to patient needs, rather than fragmented and episodic. There's a huge opportunity to try out some different payment models and delivery models. We're not going to create the perfect solution out of the box. We've talked very frankly with our board about the fact that we're not going to know the answers every time. We're going to have to experiment and innovate and be willing to say, "This isn't working the way we thought it would." We need to modify and respond to the situation on the ground.

The freedom to do that is pretty exciting. A better model and coordination of care will lower cost, improve the patient experience and create better quality, and I don't know a better ambition or dream to have than that. I think that's why people get into healthcare in the first place. ■

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# 256 Hospital and Healthcare Industry Leaders to Know

## Hospital and Healthcare Industry Leaders to Know

**B**ecker's Hospital Review has released its annual list of hospital and healthcare industry leaders to know. Here are the names of the 256 individuals included on the list. To view the full list, which contains full profiles on each leader, visit [www.beckershospitalreview.com](http://www.beckershospitalreview.com).

**Chad Aduddell.** President of Bone and Joint Hospital (Oklahoma City).

**Joel T. Allison.** President and CEO of Baylor Health Care System (Dallas).

**Steven M. Altschuler, MD.** President and CEO of Children's Hospital of Philadelphia (Pa.).

**David G. Anderson.** Senior vice president of finance and treasurer of Hospital Corporation of America (Nashville, Tenn.).

**Ron J. Anderson, MD.** CEO of Parkland Health and Hospital System (Dallas).

**Ingo Angermeier.** President and CEO of Spartanburg (S.C.) Regional Healthcare System.

**Timothy Babineau, MD.** President and CEO of Rhode Island Hospital (Providence, R.I.).

**Mark Baker.** CEO of Hughston Healthcare (Columbus, Ga.).

**Jeff Balser, MD, PhD.** Vice chancellor for health affairs and dean of Vanderbilt University School of Medicine (Nashville, Tenn.).

**Cathy Barr.** CEO of Bethesda Hospital (St. Paul, Minn.).

**David M. Barrett, MD.** President and CEO of Lahey Clinic (Burlington, Mass.).

**Warren Beck.** Senior vice president of finance and associate vice chancellor for health affairs at Vanderbilt University (Nashville, Tenn.).

**Jeremy Biggs.** CEO of St. Mary's Medical Center North (Powell, Tenn.).

**David Bixler.** President and CEO of Rutherford (N.C.) Hospital.

**Damond Boatwright.** CEO of Lee's Summit (Mo.) Medical Center.

**Bryan Bohman, MD.** Chief of staff of Stanford Hospital & Clinics and chairman of the Medical Executive Committee at Stanford (Calif.) Hospital.

**Jeffrey W. Bolton.** CFO at Mayo Clinic (Rochester, Minn.).

**Barry Bondurant.** Administrator and CEO of Baptist Memorial Hospital-Tipton (Covington, Tenn.).

**Marna P. Borgstrom.** President and CEO of Yale-New Haven (Conn.) Hospital.

**Richard M. Bracken.** Chairman and CEO of Hospital Corporation of America (Nashville, Tenn.).

**Jeff Brickman.** System senior vice president and president and CEO of Provena Saint Joseph Medical Center (Joliet, Ill.).

**Ruth W. Brinkley.** President and CEO of Carondelet Health Network (Tucson, Ariz.).

**Lynn Britton.** President and CEO of Sisters of Mercy Health System (Chesterfield, Mo.).

**Martin Brotman, MD.** President of Sutter Health's West Bay Region (Sacramento, Calif.).

**George J. Brown, MD.** President and CEO of Legacy Health (Portland, Ore.).

**Warren S. Browner, MD.** CEO of California Pacific Medical Center (San Francisco).

**Michael Bryant.** President and CEO of Methodist Health Services (Peoria, Ill.).

**Katherine Bunting.** CEO of Fairfield (Ill.) Memorial Hospital.

**Janice Burger.** CEO of Providence St. Vincent Medical Center (Portland, Ore.).

**Michael T. Burke.** Senior vice president, vice dean and corporate CFO of NYU Langone Medical Center (New York City).

**Kevin Burns.** President and CEO of University Medical Center (Tucson, Ariz.).

**Mike Butler.** CFO of Providence Health System (Renton, Wash.).

**Gary Campbell.** President and CEO of Centura Health (Englewood, Colo.).

**John Camus.** Director of physician practices at Newport (R.I.) Hospital.

**William F. Carpenter, III.** President and CEO of LifePoint Hospitals (Brentwood, Tenn.).

**Larry Cash.** CFO of Community Health Systems (Franklin, Tenn.).

**Mark Chassin, MD.** President of The Joint Commission.

**Richard Clarke.** President and CEO of the Healthcare Financial Management Association (Westchester, Ill.).

**Jack Cleary.** CEO of West Suburban Hospital (Oak Park, Ill.).

**Francis S. Collins, MD.** Director of the National Institutes of Health.

**Diane Corrigan.** CFO of the Hospitals of the University of Pennsylvania (Philadelphia).

**Delos M. Cosgrove, MD.** CEO of the Cleveland (Ohio) Clinic.

**J. Michael Cowling.** CEO of Palm Beach Gardens (Fla.) Medical Center.

**Brian Cramer.** CEO of Orthopedic Hospital of Wisconsin (Glendale, Wis.).

**Kevin Dahill.** CEO of Northern Metropolitan Hospital Association (Newburgh, N.Y.).

**Lloyd H. Dean.** President and CEO of Catholic Healthcare West (San Francisco).

**Kyle De Fur.** President of St. Vincent Indianapolis Hospital.

**Faye Deich, RN.** COO of Sacred Heart Hospital (Eau Claire, Wis.).

**Terrence G. Deis.** President and CEO of Parma (Ohio) Community General Hospital.

**John Dietz, Jr., MD.** Spine surgeon at OrthoIndy (Indianapolis).

**Ralph de la Torre, MD.** President and CEO of Caritas Christi Health Care System (Brighton, Mass.).

**Robert A. DeMichiei.** Senior vice president and CFO of University of Pittsburgh (Pa.) Medical Center.

**Chris Denton.** CFO of Henrico Doctors' Hospital (Richmond, Va.).

**Nancy-Ann DeParle, JD.** Director of the White House Office of Health Reform (Washington, D.C.).

**Michael J. Dowling.** President and CEO of North Shore-Long Island Jewish Health System (Manhasset, N.Y.).

**Edward Downs.** CEO of South Hampton Community Hospital (Dallas).

**Michael Duffy.** CEO of Methodist Hospital (San Antonio).

**Michael E. Duggan.** President and CEO of Detroit Medical Center.

**Victor J. Dzau, MD.** Chancellor for health affairs at Duke University and president and CEO of Duke University Health System (Durham, N.C.).

**Todd Ebert.** President and CEO of Amerinet (St. Louis).

**Laurie Eberst, RN.** President and CEO of Catholic Healthcare West Ventura County Market Service Area and St. John's Regional Medical Center (Oxnard, Calif.).

**Duane L. Erwin.** President and CEO of Aspirus (Wausau, Wis.).

**Melinda Estes, MD.** President and CEO of Fletcher Allen (Burlington, Vt.).

**Pat Farrell.** CEO of Henrico Doctors' Hospital (Richmond, Va.).

**David T. Feinberg, MD.** CEO of UCLA Hospital System.

**Joseph G. Felkner.** CFO of Lehigh Valley Hospital (Allentown, Pa.).

**Rick Ferguson.** CEO of the Oklahoma Surgical Hospital (Tulsa, Okla.).

**Trevor Fetter.** President and CEO of Tenet Healthcare (Dallas).

**Peter S. Fine.** President and CEO of Banner Health (Phoenix, Ariz.).

**Thomas B. Flynn, MD.** President and founder of NeuroMedical Center (Baton Rouge, La.).

**Georgia Fojtasek.** President and CEO of Allegiance Health (Jackson, Mich.).

**Michael Foley, MD.** Chief medical officer of Scottsdale (Ariz.) Healthcare.

**O. Edwin French.** President and CEO of MedCath (Charlotte, N.C.).

**Joe Freudenberger.** CEO of OakBend Medical Center (Richmond, Texas).

**Patrick Fry.** President and CEO of Sutter Health (Sacramento, Calif.).

**Steven G. Gabbe, MD.** Senior vice president for health sciences and CEO of Ohio State University Medical Center (Columbus, Ohio).

**Patricia Gabow, MD.** CEO of Denver (Colo.) Health.

**J.P. Gallagher.** President of Evanston (Ill.) Hospital.

**George Gaston.** CEO of Memorial Hermann Southeast Hospital (Houston).

**Michael Geier, MD.** President of medical staff at Providence Regional Medical Center (Everett, Wash.).

**Reginald Gibson.** Vice president and associate general counsel at Health Management Associates (Naples, Fla.).

**Ron Girotto.** President and CEO of Methodist Hospital and Methodist Hospital System (Houston).

**Steven C. Glass.** CFO of Cleveland (Ohio) Clinic.

**Aaron E. Glatt, MD.** President and CEO of St. Joseph Hospital (Bethpage, N.Y.).

**Talitha Glosemeyer.** Administrator and CEO of Norman (Okla.) Specialty Hospital.

**Joseph Golbus, MD.** President of North-Shore University HealthSystem Medical Group (Evanston, Ill.).

**Richard Goldberg, MD.** President of Georgetown University Hospital (Washington, D.C.).

**Larry J. Goodman, MD.** President and CEO of Rush University Medical Center (Chicago).

**Deborah L. Gorbach.** Vice president of accounting of Akron (Ohio) General Medical Center.

**Brett Gosney.** Founder, partner and the CEO of Animas Surgical Hospital (Durango, Colo.).

**Gary Gottlieb, MD.** President and CEO of Partners Health System (Boston).

**Pauline Grant.** CEO of North Broward Medical Center (Pompano Beach, Fla.).

**Steven D. Grant, MD.** Executive vice president of physician partnerships at Detroit Medical Center.

**Barbara Greene.** President of Franciscan Physicians Hospital (Munster, Ind.).

**Robert I. Grossman, MD.** CEO of NYU Langone Medical Center and dean of the NYU School of Medicine (New York City).

**Dean Gruner, MD.** President and CEO of ThedaCare (Appleton, Wis.).

**Glenn M. Hackbarth, JD.** Chairman of MedPAC.

**John Hagale.** CFO of Methodist Health Care System (Houston).

**Chuck J. Hall.** President of the Eastern Group of Hospital Corporation of America (Nashville, Tenn.).

**Jesse Peterson Hall.** President of Highland Park (Ill.) Hospital.

**Michael Halter.** CEO of Hanhemann University Hospital (Philadelphia).

**George C. Halvorson.** Chairman and CEO of Kaiser Permanente (Oakland, Calif.).

**Misty Darling Hansen.** CFO of University Medical Center (Tucson, Ariz.).

# 256 Hospital and Healthcare Industry Leaders to Know

**Marc Harrison, MD.** Chief medical operations officer of Cleveland (Ohio) Clinic.

**Dean M. Harrison.** President and CEO of Northwestern Memorial HealthCare and Northwestern Memorial Hospital (Chicago).

**John Harvey, MD.** Medical director and CEO of Oklahoma Heart Hospital (Oklahoma City, Okla.).

**Debbie Hay, RN, BSN.** President of the Texas Institute for Surgery (Dallas).

**Samuel N. Hazen.** President of the Western Group of Hospital Corporation of America (Nashville, Tenn.).

**Dennis R. Herrick.** Senior vice president of finance of Beaumont Hospital (Royal Oak, Mich.).

**Cathryn Hibbs.** CEO of Deaconess Hospital (Oklahoma City, Okla.).

**Jeffrey H. Hillebrand.** COO of NorthShore University HealthSystem (Evanston, Ill.).

**Rodney Hochman, MD.** CEO of Swedish Medical Center (Seattle).

**M. Michelle Hood.** President and CEO of Eastern Maine Healthcare Systems (Brewer, Maine).

**Lars Houmann.** President and CEO of Florida Hospital (Orlando, Fla.).

**Constance A. Howes.** President and CEO of Women & Infants Hospital of Rhode Island (Providence, R.I.).

**Karen Ignani.** President of America's Health Insurance Plans.

**Keith B. Isaacson, MD.** Medical director at Newton-Wellesley Hospital (Newton, Mass.).

**Catherine A. Jacobson.** CFO and treasurer at Rush University Medical Center (Chicago).

**Deborah Carey Johnson, RN.** President and CEO of Eastern Maine Medical Center (Bangor, Maine).

**Douglas V. Johnson.** COO of RMC Medstone Capital (Dallas).

**Jay Johnson.** President and CEO of Duncan (Okla.) Regional Hospital.

**R. Milton Johnson.** Executive vice president and CFO of Hospital Corporation of America (Nashville, Tenn.).

**Charles "Chip" Kahn III.** President of the Federation of American Hospitals.

**Laura Kaiser.** President and CEO of Sacred Heart Health System (Pensacola, Fla.).

**Gary S. Kaplan, MD.** Chairman and CEO of Virginia Mason Medical Center (Seattle).

**Thomas Karl.** President of Parkland Health Center (St. Francois County, Mo.).

**Donna Katen-Bahensky.** President and CEO of the University of Wisconsin Hospital and Clinics (Madison, Wis.).

**Bill Keaton.** CEO of Baylor Medical Center (Frisco, Texas).

**A. Gus Kiouss, MD.** President of Huron Hospital (Cleveland, Ohio).

**Kevin Klockenga.** President and CEO of St. Joseph Health-Sonoma County (Santa Rosa, Calif.).

**Alfred B. Knight, MD.** President and CEO of Scott & White (Temple, Texas).

**Ben Koppelman.** President and CEO of St. Joseph's Area Health Services (Park Rapids, Minn.).

**John Koster, MD.** President and CEO of Providence Health & Services (Renton, Wash.).

**Kelby Krabbenhoff.** President and CEO of Sanford Health (Sioux Falls, S.D.).

**Mark Krieger.** Vice president and CFO of Barnes-Jewish Hospital (St. Louis).

**Sanjaya Kumar, MD.** President, CEO, and Chief Medical Officer of Quantros (Milpitas, Calif.).

**Mark Laney, MD.** President of Heartland Health (St. Joseph, Mo.).

**Dennis Laraway.** CFO of Scott & White Healthcare (Temple, Texas).

**Mark R. Laret.** CEO of UCSF Medical Center (San Francisco).

**Robert J. Laskowski, MD.** President and CEO of Christiana Care Health System (Wilmington, Del.).

**Chuck Lauer.** Former editor of *Modern Healthcare*.

**Bruce Lawrence.** President and CEO of Integrity Health (Oklahoma City).

**Bill Leaver.** President and CEO of Iowa Health System (Des Moines, Iowa).

**Mary Jo Lewis.** CEO at Sumner Regional Health Systems (Gallatin, Tenn.).

**Richard J. Liekweg.** President of Barnes-Jewish Hospital (St. Louis).

**Mike Lipomi.** President of RMC MedStone (Dallas).

**Steven H. Lipstein.** CEO and president of BJC Healthcare (St. Louis).

**Kevin E. Lofton.** President and CEO of Catholic Health Initiatives (Englewood, Colo.).

**James V. Luck Jr., MD.** President, CEO and medical director of Orthopaedic Hospital (Los Angeles).

**Roberta Luskin-Hawk, MD.** CEO of Saint Joseph Hospital (Chicago).

**Michael Lutes.** CEO of Carolinas Medical Center-Union (Monroe, N.C.).

**James Mandell, MD.** CEO of Children's Hospitals (Boston).

**Peter Marmarstein.** CEO of the Chippenham Campus of CJW Medical Center (Richmond, Va.).

**Charles Martin, Jr.** Chairman and CEO of Vanguard Health System (Nashville, Tenn.).

**Sally A. Mason Boemer.** Senior vice president for finance at Massachusetts General Hospital. (Boston).

**Michael Maves, MD.** Executive vice president and CEO of the American Medical Association.

**John McCabe, MD.** CEO and Senior Vice President for clinical affairs at University Hospital (Syracuse, N.Y.).

**Peter J. McCanna.** CFO and Executive Vice President for administration at Northwestern Memorial Healthcare as well as Northwestern Memorial Hospital (Chicago).

**Vincent J. McCorkle.** President and CEO at Akron (Ohio) General Medical Center.

**Mark McDonald, MD.** President and CEO of the Institute for Orthopaedic Surgery (Lima, Ohio).

**Gene F. Michalski.** CEO of Beaumont Hospital (Royal Oak, Mich.).

**Thomas A. Michaud.** CEO and board chairman founded Foundation Surgery Affiliates (Oklahoma City).

**Alan Miller.** CEO and chairman of Universal Health Services (King of Prussia, Pa.).

**Edward D. Miller, MD.** President of Johns Hopkins Medicine, dean of the Johns Hopkins University School of Medicine and vice president for medicine of Johns Hopkins University (Baltimore).

**Marc D. Miller.** President of Universal Health Services (King of Prussia, Pa.).

**Dan Moen.** CEO of Legacy Hospital Partners (Plano, Texas).

**Daniel J. Morissette.** CFO of Stanford (Calif.) Hospital and Clinics.

**David Morlock.** CFO of University of Michigan Health System (Ann Arbor, Mich.).

**Edward G. Murphy, MD.** President and CEO of Carilion Clinic (Roanoke, Va.).

**Elizabeth G. Nabel, MD.** President of Brigham and Women's and Faulkner Hospitals (Boston).

**Harris M. Nagler, MD.** President and CEO of Beth Israel Medical Center Manhattan (N.Y.).

**Mark Neaman.** President and CEO of North-Shore University HealthSystem (Evanston, Ill.).

**Robert E. Nesse, MD.** CEO of Mayo Health System (Rochester, Minn.).

**Stephen L. Newman, MD.** COO of Tenet Healthcare Corporation (Dallas)

**Gary D. Newsome.** President and CEO of Health Management Associates (Naples, Fla.).

**Sister Mary Norberta.** President and CEO of St. Joseph Healthcare and St. Joseph Hospital (Bangor, Maine).

**John Noseworthy, MD.** President and CEO of Mayo Clinic (Rochester, Minn.).

**Christopher T. Olivia, MD.** President and CEO of West Penn Allegheny Health System (Pittsburgh, Pa.).

**Herbert Pardes, MD.** President and CEO of the New York Presbyterian Health Care System (New York City).

**David Pate, MD.** President and CEO of St. Luke's Health System (Boise, Idaho).

**Ronald Paulus, MD.** CEO of Mission Health System and Mission Hospital (Asheville, N.C.).

**Judith M Persichilli, RN, BSN.** Executive vice president and COO of Catholic Healthcare East (Newtown Square, Pa.).

**Jonathan Perlin, MD.** Chief medical officer and president of the clinical services group for Hospital Corporation of America (Nashville, Tenn.).

**Ronald R. Peterson.** President of Johns Hopkins Hospital and Johns Hopkins Health System (Baltimore).

**Wright Pinson, MD.** CEO of hospitals and clinics at Vanderbilt University Medical Center, deputy vice chancellor for health affairs and associate vice chancellor for clinical affairs at Vanderbilt (Nashville, Tenn.).

**Kenneth Polonsky, MD.** Dean of the division of biological sciences at the Pritzker School of Medicine and executive vice president for medical affairs at the University of Chicago. (Chicago)

**Karen Poole.** Vice president and COO of the Boca Raton Community Hospital (Boca Raton, Fla.).

**Andrea Price.** CEO of Mercy Health Partners (Cincinnati, Ohio).

**Thomas Priselac.** President and CEO of Cedars-Sinai Health System (Los Angeles).

**Edward Prunchunas.** Senior vice president of finance and CFO of Cedars-Sinai Medical Center (Los Angeles).

**Joseph A. Quagliata.** President and CEO of South Nassau Communities Hospital (Oceanside, N.Y.).

**Patrick J. Quinlan, MD.** CEO of Ochsner Health System (New Orleans).

**James P. Rayome.** Division vice president and associate general counsel of Community Health Systems (Franklin, Tenn.).

**Michael Reney.** CFO of Brigham and Women's and Faulkner Hospitals (Boston).

**Lex Reddy.** President and CEO of Prime Healthcare (Ontario, Calif.).

**Prem Reddy, MD.** Chairman and founder of Prime Healthcare Services (Ontario, Calif.).

**John Rex-Waller.** Chairman, president and CEO of National Surgical Hospitals (Chicago).

**Britt Reynolds.** Division president of Health Management Associates (Naples, Fla.).

**Jeffrey A. Romoff.** President and CEO of UPMC in Pittsburgh (Pa.).

**Steve Ronstrom.** President of the Western Wisconsin Division of Hospital Sisters Health System at Sacred Heart Hospital (Eau Claire, Wis.).

**William L. Roper, MD.** CEO of the UNC Health Care System at the University of North Carolina at Chapel Hill (N.C.).

**David Ross.** CEO and president of St. Joseph's Hospital (Nashua, N.H.).

**Michael Rowan.** Executive vice president and COO of Catholic Health Initiatives (Denver, Colo.).

**Thomas Royer, MD.** President and CEO of CHRISTUS Health (Irving, Texas).

**Kathryn Ruscitto.** President and CEO of St. Joseph's Hospital Health Center (Syracuse, N.Y.).

**Linda B. Russell.** CEO of The Women's Hospital of Texas (Houston).

**Michael E. Russell, II, MD.** Orthopedic surgeon at Azalea Orthopedics (Tyler, Texas).

**Christina M. Ryan.** CEO of The Women's Hospital (Evansville, Ind.).

**Sister Mary Jean Ryan.** President and CEO of SSM Health Care (St. Louis).

**Lee Sacks, MD.** President of Advocate Physicians Partners and executive vice president and CMO for Advocate Health Care (Oak Brook, Ill.).

**Steven M. Safyer, MD.** President and CEO of Montefiore Medical Center (New York City).

# 256 Hospital and Healthcare Industry Leaders to Know

**Scott Serota.** President and CEO of the Blue Cross and Blue Shield Association.

**Garry Scheib.** Executive director of the Hospital of University of Pennsylvania (Philadelphia).

**Nancy Schlichting.** President and CEO of the Henry Ford Health System (Detroit).

**Rachel Seifert.** Executive vice president, secretary and general counsel of Community Health Systems (Brentwood, Tenn.).

**James Moore.** CEO of OSF Healthcare (Peoria, Ill.).

**Gregory Simone, MD.** President and CEO of WellStar Health System (Atlanta).

**James H. Skogsbergh.** President and CEO of Advocate Health Care (Oak Brook, Ill.).

**Peter Slavin, MD.** President of Massachusetts General Hospital (Boston).

**Daniel Slipkovich.** CEO of Capella Healthcare (Franklin, Tenn.).

**Wayne Smith.** President and CEO of Community Health Systems (Brentwood, Tenn.).

**Charles W. Sorenson, MD.** President and CEO of Intermountain Healthcare (Salt Lake City, Utah).

**Dale Sowders.** President and CEO of Holland (Mich.) Hospital.

**Kevin Sowers.** CEO of Duke University Hospital (Durham, N.C.).

**Rulon F. Stacey, PhD.** President and CEO of Poudre Valley Health System (Fort Collins, Colo.).

**James M. Staten.** Executive vice president for corporate and financial services of the Yale-New Haven (Conn.) Health System.

**Paul Staton.** CFO of UCLA Medical Center (Los Angeles).

**Richard J. Statuto.** President and CEO of Bon Secours Health System (Marriottsville, Md.).

**Glenn Steele, Jr., MD.** President and CEO of Geisinger Health System (Danville, Pa.).

**Robert Steigmeyer.** CEO of Community Medical Center (Scranton, Pa.).

**John B. Stone.** CFO at the Ohio State University Medical Center (Columbus, Ohio).

**Douglas L. Strong.** CEO of University of Michigan Hospitals and Health Centers (Ann Arbor, Mich.).

**Steven L. Strongwater, MD.** CEO of Stony Brook (N.Y.) University Medical Center.

**Paul Summerside, MD.** Chief medical officer of BayCare Clinic (Green Bay, Wis.).

**Elliot J. Sussman, MD.** President and CEO of Lehigh Valley Hospital and Health Network (Allentown, Pa.).

**Joseph R. Swedish.** President and CEO of Trinity Health (Novi, Mich.).

**Michael C. Tarwater.** CEO of Carolinas HealthCare System (Charlotte, N.C.).

**Anthony Tersigni.** President and CEO of Ascension Health (St. Louis).

**Larry Teuber, MD.** President of Medical Facilities Corporation (Ontario, Canada).

**Peggy Troy.** CEO of Children's Hospital and Health System (Milwaukee).

**Nick Turkal, MD.** President and CEO of Aurora Health Care (Milwaukee).

**Richard Umbdenstock.** President and CEO of the American Hospital Association.

**Kevin L. Unger.** President and CEO of Poudre Valley Hospital (Fort Collins, Colo.).

**David Vandewater.** President and CEO of Ardent Health Services (Nashville, Tenn.).

**Chris Van Gorder.** President and CEO of Scripps Health (San Diego).

**Sandra A. Van Trease.** Group president for hospitals operated by BJC Healthcare located (St. Louis).

**Harold Varmus, MD.** President of Memorial Sloan-Kettering (New York City).

**Anita S. Vaughn, RN.** Administrator and CEO of Baptist Memorial Hospital for Women (Memphis, Tenn.).

**Gary Weiss.** Executive vice president, CFO and treasurer of NorthShore University HealthSystem (Evanston, Ill.).

**Ronald J. Werthman.** Vice president for finance of Johns Hopkins Health System (Baltimore, Md.).

**Paul K. Whelton, MD.** President and CEO of Loyola University Health System (Chicago).

**David R. White.** Chairman, founder and CEO of IASIS Healthcare (Franklin, Tenn.).

**Guy R. Wiebking.** President and CEO of Provena Health (Mokena, Ill.).

**Jeffrey P. Williams.** CFO of St. Vincent Indianapolis Hospital.

**Nicholas Wolter, MD.** CEO of Billings (Mont.) Clinic.

**Dan Wolterman.** President and CEO of Memorial Hermann Healthcare System (Houston). ■



## 5 Best Practices to Prepare Hospitals for Accountable Care

By Laura Miller

The government's encouragement of coordinated care is leading many hospitals to consider developing or joining accountable care organizations, and healthcare futurist Joe Flower, who works with clients ranging from World Health Organization to Global Business Network, says the move is good business practice. He says becoming an ACO can improve the hospital's bottom line by producing more efficient and less expensive healthcare.

"There is a lot of room in healthcare to achieve better quality at lower cost," says Mr. Flower. "Hospitals need to think of themselves as a medical home in partnership with the physician community. It's a very different way of looking at healthcare and I think everyone is struggling with it."

Here are five best practices Mr. Flower believes hospitals and health networks should implement in order to prepare themselves for this future.

**1. Digitize and automate.** Hospitals should implement CPOE, EMRs or EHRs, and then fully digitize and automate "[everything] from images to security to labs to pharmacy to physical inventory." These systems also allow the hospitals to mine the data for health patterns, such as chronic disorders or illnesses, so the patients receive the appropriate treatment regarding their condition. Digitized and automated systems also allow the hospital to mine the data for quality and efficiency to drive their own production system. "Healthcare is a production system," says Mr. Flower. Failing to optimize the production system for full efficiency and effectiveness leads to poor patient experiences and treatment outcomes, as well as a troubled bottom line.

**2. Integrate with the physicians.** Hospitals have several options for collaborating with physicians, such as bringing the physicians on staff, joint venturing with multispecialty groups or specialty hospitals and forming primary healthcare organizations. The right model depends on the location situation: The physicians, the patient population and other assets the hospital can deploy. Hospital administrators can compare their primary care operations and partnerships to the standards for the "Medical Home" put out by the National Committee for Quality Assurance. Either way, hospitals should engage the physicians within the hospital leadership decision-making processes regarding the goals and incentives necessary for improving quality or becoming an ACO.

"All of these relationships have to be specifically managed through the limbs of a production system for the greatest quality and efficiency," says Mr. Flower. "If you look at places where implementing goals and incen-

tives for physicians has failed, they are places where the administrators make up an incentive program and tell the doctors, "This is what we're going to do."

**3. Emphasize primary care.** When designing the ACO model, hospitals should begin with the primary care physicians and work upward. Patients with acute problems often visit clinics, ERs or urgent care centers, which is more costly and less time-efficient than utilizing a primary care physician. "There is increasing data that our primary care sector is suffering because it is difficult for patients to find primary care physicians and difficult for primary care physicians to make a living," says Mr. Flower. "Hospitals need to either build their own primary care networks or strongly partner with independent physicians in order to create a seamless patient experience and to help the physicians maximize their efficiency and effectiveness."

Mr. Flower says many primary care physicians spend their time on unbillable tasks, such as chasing down claims and coding, which does not contribute to a patient's care. Building staff or appropriate technologies to streamline these tasks, in effect, creates more primary care physicians by allowing them to spend more of their time on patient care.

**4. Share risks.** Hospitals need to share the risks involved with healthcare payments between themselves, the insurance company, patients and physicians. Hospitals can share the risk by implementing a capitated payment system (healthcare providers paid for each assigned patient, such as the HMO system) or minicaps (a subscription system).

**5. Utilize management tools.** In order to increase organization and efficiency at the hospital, administrators should employ management tools such as the Toyota Production System. For instance, Seattle Children's Hospital, which implemented a version of the Toyota Production System, was able to increase the number of patients it cared for by 50 percent in five years without adding any new beds or staff, says Mr. Flower.

There are a wide variety of "new management" tools, from Six-Sigma quality techniques to "Theory of Constraints" analysis, to benchmarking, to the Toyota Production System, each appropriate for particular parts of managing healthcare. You can think of them as a toolbox, he says.

"Hospitals have heard a lot about these management tools. Some hospitals are applying them strongly, many are not," says Mr. Flower. "I think in a world where hospitals are shifting to ACOs, these tools are very valuable." ■

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# Is Your Organization Ready For Accountable Care? How to Implement a Readiness Assessment and Establish Priorities

By Laurie Shiparksi, RN, BSN, MS, Senior Vice President, Verras Consulting

Many healthcare leaders are strategizing to meet the requirements of section 3022 of the Patient Protection and Affordable Care Act. This historic passage of legislation to reform our nation's healthcare is requiring new thinking and action. Although many of the specifics of the reform act are not yet defined, healthcare organizations can be proactive and strategically position themselves for success. With expected reimbursement decreased by 20-25 percent, new systems and networks will be developed between providers. The first step is for leaders to become educated on what is known about Accountable Care Organizations and then assess where their organization is in relation to the known requirements.

## Building a roadmap to readiness

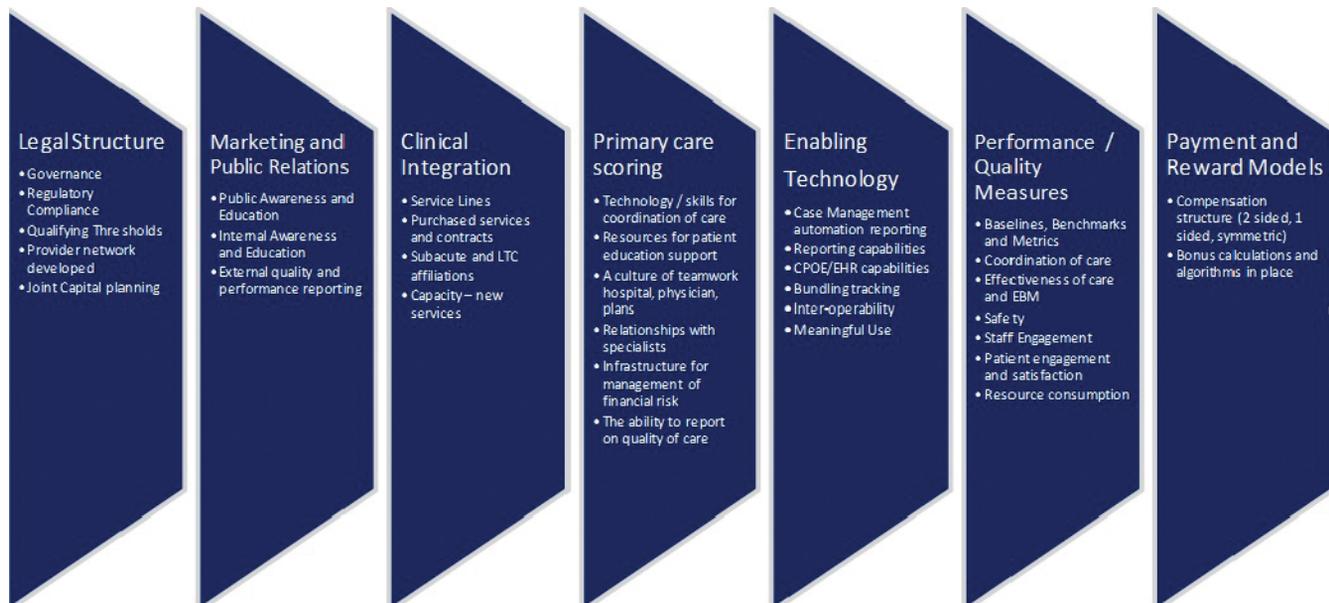
A readiness assessment process is necessary to aid healthcare organizations in comprehensively evaluating their strengths and priorities as they progress toward accountable care. This is one approach that identifies seven assessment categories that are critical to address for success in today's market. This process can help organizations meet their current challenges and develop a roadmap for building a higher performing organization. An ACO should be centered on providing an excellent patient experience and it should produce outcomes that indicate they are controlling costs, and improving quality. The assessment must address these areas and more. There is no doubt that this is work already in progress in many organizations but the difference is the shift in accountability to be assumed in new partnerships between physicians and hospitals. The goal is to build on the good work in progress and target the high priority areas for change.

## Assessment approach

A formula for success includes an experienced leadership team using analytical tools and data to comprehensively look at the current processes and outcomes related to creating a successful environment of Accountable Care. Through the use of technology it is possible to identify clinical variations and opportunities to reduce resource consumption and increase throughput in the organization. Physician-driven collaboration with the hospital is key to maintaining hospitals' profitability through clinical cost containment while minimizing the potential of compromising care. Using physician-directed process improvements, the hospital can make data-driven decisions that reduce the use of hospital resources, obviate costly errors and control variations in care delivery that compromise medical outcomes.

## Assessment components

In this process there are over 300 key checkpoints critical to understanding the level of preparedness for each of the seven assessment categories. Each of the 300 indicators can be reviewed, weighted and scored numerically to gauge readiness. In addition to the clinical performance data, the approach should include web-based surveys, data requests, workshops/interviews, capacity mapping and process reviews to identify both operational and strategic actions required to move forward with a coordinated care delivery model design.



Seven Assessment Categories

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\*In anticipation that Congress may not further delay after November 2010, a 21.2 percent reduction in the Medicare physician fee conversion factor, resulting in a blanket reduction in physician fee schedule payments under Medicare Part B.

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## Readiness Assessment Components

1. Review up to 300 checkpoints in 7 categories
2. Conduct an estimated 30-40 interviews
3. Align clinical performance with operational opportunities
4. Outline specific actions required for the development of new network strategies
  - Baselines for reward and shared savings scenarios (3 year requirements)
  - EHR/EMR guidance
  - Evidence-based medicine and patient engagement
  - Reporting on quality and cost measures
  - Compliance with the patient-centeredness criteria
5. Assess current market service line capacities
6. Identify educational requirements
7. Create a detailed findings report for use with senior management and board member communication

### Readiness Assessment Time frame (4-6 weeks)

The readiness assessment should be customized to incorporate any work already completed or in-process. Cost and quality data currently collected can be utilized and further analyzed in the assessment. This in combination with the newly obtained assessment results will complete the readiness picture. It is critical that this assessment be done in a concise time period. The following identifies time frames for activities to be completed within 4-6 weeks.

#### Weeks 1-2

The initial weeks are the time to do a behind-the-scenes review of opera-

tions and data within the seven areas of readiness. The internal and external stakeholders should be identified for involvement in the assessment. A series of interviews can be conducted with key senior leadership and other professionals identified. The interviews focus on questions that align with the seven areas of accountable care priorities as well. These interviews will be designed to uncover a broad understanding of the hospital and physician general operations and integration. The interviews will also serve to enhance communication, build relationships and identify concerns. The strengths and weaknesses of clinical coordination and integration can be determined and the initial opportunities for enhancements identified. A technical assessment should be done of the quality and cost data. This assessment will identify variations in delivery of care and consumption of resources

#### Weeks 3-4

During these weeks, the data and information collected can be collated and analyzed. This includes scoring of all the check points within the seven areas. The scoring system can help identify the lower areas that need to be progressed to full readiness. Once the full picture is revealed, the leadership team can begin outlining actions required to maintain areas of high effectiveness and address areas of low readiness. This calls for discussion and dialogue to create innovative approaches to move forward.

#### Weeks 5-6

Presentations of identified finding and opportunities are made to validate them can be made to stakeholders to generate additional ideas and input. There may also have been some educational needs related to accountable care identified for key groups or individuals that can be delivered in conjunction with the organizational results.

### Moving toward 2013

Following the data collection and planning phases of the readiness assessment, it is critical to establish ongoing monitoring, training, coaching and development of processes to capture the requirements for clinical integration/sharing strategies, primary care framework and performance/quality reporting. The leadership team and identified stakeholders can use the results to build scenarios and create new possibilities to achieve desired outcomes. The readiness assessment is the basis for the continued planning and action. As new information becomes available the leadership team must have the capacity to be flexible and adjust to new information and circumstances. Readiness assessment findings will assist healthcare leaders in making informed decisions and developing focused strategies as healthcare regulatory change begins in 2011. A comprehensive approach such as this one is necessary if healthcare organizations want to not only "Survive but

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# 5 Key Regulatory Concerns for ACOs

By Lindsey Dunn

Hospitals looking to develop accountable care organizations face the same regulatory concerns and hurdles that hospitals have long grappled with in their physician integration efforts. Specifically, ACOs must ensure that their agreements with physicians do not violate anti-kickback statutes, Stark Law, the Civil Monetary Penalty, tax-exemption laws and/or anti-trust regulations.

Previous and current Medicare demonstration projects involving bundled or incentive payments have granted exceptions to many of these regulations, and it is expected the Medicare ACO demonstration created by the Patient Protection and Affordable Care Act will do the same, although specific guidelines for the project will not be released until December. Given that specific guidelines are forthcoming, hospitals that develop ACOs must consider how their integration efforts will be viewed in light of these regulations.

**1. Anti-kickback statutes.** Federal and state anti-kickback statutes prohibit the accepting of cash or any item of value in return for the referral of health services that are later billed, in whole or part, to federal healthcare programs. The cardinal issue under the anti-kickback statutes is whether the relationships being structured are really a means to pay physicians for referrals, says Scott Becker, JD, CPA, partner at McGuire-Woods. “Are the physicians being overpaid professional fees to refer cases or are they getting to own a greater part of an ACO due to referrals, or is a management arrangement really a guise to provide payment for referrals?” he says.

The federal statute does however provide “safe harbors” for certain relationships. If a hospital is developing an ACO, one of the most direct ways to ensure a complaint relationship is to employ physicians, as direct employment fulfills a safe harbor. The statute also provides for safe harbors for certain independent contractor agreements.

Lisa Bielamowicz, MD, managing director and national physician practice leader for the Health Care Advisory Board, cautions that hospitals should not use employment as its sole physician alignment vehicle. “Employment does not equal integration,” she says. “Integration needs to be implemented through the creation of performance-based incentives that reward physicians for high quality, low cost care.”

Rob Lazerow, a consultant with the Health Care Advisory Board, adds employment should only be used as an integration strategy if it fits within the hospital’s strategic needs. “In an ACO environment that clearly encourages the management of chronic diseases, an investment in primary care infrastructure is critical, so employment of these providers may be effective,” he says. How-

ever, other physicians, such as general surgeons, radiologists, etc., may not need to be employed to get them aligned with the ACO. Here, the ACO could structure bundled pricing or gainsharing programs to bring them closer to the ACO without necessarily bringing them under the “risk sharing umbrella,” adds Dr. Bielamowicz.

Hospitals must ensure these other non-employment arrangements do not violate anti-kickback laws. Although similar, bundled payment and gainsharing programs differ in one important way — who’s footing the bill. In gainsharing programs, a hospital provides some form of compensation to physicians for meeting certain quality and efficiency standards. In a bundled payment program, an insurer provides a lump sum payment for hospital and physician services at a contracted rate, and then the hospital and physicians divide any savings created by delivering care at an amount below that rate, says Mr. Lazerow.

Gainsharing programs that pay a percentage of cost savings are not covered by an explicit safe harbor, but the HHS Office of Inspector General has issued favorable guidance for the programs. Because gainsharing is not covered explicitly by a safe harbor, organizations should take a conservative stance and seek legal counsel when entering into such relationships, cautions Mr. Lazerow.

Finally, more traditional co-management arrangements are yet another way a hospital-led ACO might try to create alignment. These relationships can be structured to fit under the federal Anti-Kickback Statute’s personal services and/or management contracts safe harbors. However, to meet these safe harbors, the compensation must be set wholly and in aggregate in advance.

**2. Stark law.** Related to the Anti-Kickback Statute, but a civil rather than a criminal statute, Stark law prohibits referrals for certain designated health services by healthcare providers to entities in which they have a financial interest, unless certain exceptions are met. The “bona fide” employment of physicians is one exception included in the law. This allows systems to employ doctors and pay them as employees while accepting their referrals. Most co-management arrangements can also be structured to meet an exception under the Stark Act, says Mr. Becker. The Stark law does not have a specific exception regarding ACOs or gainsharing programs. (An exception was proposed in 2008 but has yet to be finalized.) However, it is often possible to structure ACO relationships and gainsharing programs to meet other exceptions, such as the personal services arrangement and/or fair market value exceptions.

**3. Civil Monetary Penalty.** The Civil Monetary Penalty gives the Department of Health

and Human Services Secretary the power to impose civil penalties for various forms of fraud and abuse. The CMP prohibits hospitals or other providers that knowingly make a payment or offer any other form of inducement to reduce or limit items or services to fee-for-service Medicare or Medicaid beneficiaries. Because co-management, bundled payments and gainsharing agreements that may be entered into by ACOs generally intend to improve efficiency, the CMP is another regulatory concern for these groups. As a result, those designing arrangements with physician should be very careful in how they discuss the manner in which they aim to improve efficiency and control cost but not aim to or include incentives to provide less than optimal care, says Mr. Becker.

**4. Tax exemption laws.** Additionally, non-profit, tax-exempt hospitals are subject to certain additional requirements. Most notably, tax-exempt hospitals who participate in ventures must assure that the venture serves community purposes and that the venture does not provide private benefit to others.

**5. Anti-Trust Law.** Finally, ACOs should be aware that federal and state anti-trust laws may apply to their arrangements. Since 1996, providers have been allowed to contract together as part of clinical integration arrangements. However, there is some controversy today on the extent of some of these arrangements on whether or not they should be considered collusive, says Dr. Bielamowicz. Healthcare reform legislation encourages providers to align more closely and work together, but the development of ACOs will consolidate the market, which brings up questions about whether they may end up with too much leverage in some markets, she says.

Mr. Lazerow adds, “What’s helpful for Medicare — a well coordinated, integrated delivery system — is very different than what promotes free market competition. What’s good for Medicare versus what’s good for commercial payors may not be the same thing.”

ACOs that participate in the Medicare pilot will avoid anti-trust issues as long as the government unilaterally sets payments, the Federal Trade Commission has said. However, tensions persist for ACOs that enter into agreements with commercial payors as these relationships have yet to be re-addressed by regulators in the wake of health reform. The FTC plans to solicit public opinion this fall as it works to develop policies on competition and reimbursement as they relate to ACOs. As such, providers can expect updated regulations and guidance as the government works out how to best address these issues. ■

# To Run ACOs, Hospitals Need to Change Their Business Model

By Leigh Page

Hospitals looking to run accountable care organizations will have to change their business model from admitting as many patients as possible to learning how to reduce expenses, says Donald H. Crane, president and CEO, California Association of Physician Groups.

Mr. Crane suggests large physician groups have a more legitimate claim to run ACOs. CAPG consists of 150 large medical groups and independent practice associations, representing 59,000 physicians, or about two-thirds of all physicians in the state.

“It’s interesting to see how the ACO provisions evolved,” he says. “The House version of the reform bill did not mention hospitals as running ACOs, then the Senate version did.

“Why do you think hospitals weren’t mentioned in the House version?” he says. “There are many exceptions but in most parts of the country, the hospital business model has to do with an inpatient model – ‘heads in beds,’ maximizing revenues. In an ACO, however, the goal is to reduce expenses, which is not what most hospitals do. So the ACO

model poses a challenge to hospitals.”

Even apart from ACOs, he says hospitals are under great pressure to change. “Put yourself in the shoes of a hospital CEO,” Mr. Crane says. “You’re getting a message – change your business model.” The healthcare reform law “develops a host of imperatives for hospitals: readmissions, never events, value-based purchasing,” he says. “All of these require a higher level of integration with physicians.”

## Physician groups eager to lead

If hospitals don’t run an ACO, they have the option of partnering with physician groups or serving as a contracted vendor for an ACO, Mr. Crane says.

Physician groups are very interested in ACOs. At meetings, “we talk about ACOs all day long,” Mr. Crane says. “To a great extent, it’s old wine in new bottles. It’s already our business model.”

Mr. Crane says the ACO model is very similar to a capitated model, where providers get a set pay-

ment for all services and have to keep expenses in check. While physician groups in the rest of the country pretty much abandoned the model, capitation remains an important source of payment for CAPG members, he says.

## Unresolved issues

Mr. Crane says he traveled to Baltimore last week, met with CMS officials who are currently writing the ACO regulations and shared his thoughts with them.

A number of issues will need to be resolved in the regulations, he says. For example, “We don’t know how much of the population will move into ACOs.” And will the ACO have to accept any physician who wants to join? Or will the ACO be able to choose who gets in? And if the hospital doesn’t get into the ACO, would it lose its Medicare patients?

Eventually he also expects eventually there be disincentives for providers who don’t join ACOs. “That isn’t in the law, but it could happen down the line,” he says. ■

# ACOs May Cause Healthcare Cost Inflation Rather than Savings

By Leigh Page

Rather than save money, some experts argue accountable care organizations will further inflate prices, as hospitals unite with physicians and other providers against private insurers, according to a report by the *Washington Post*.

In an article on the effect of hospital mergers on healthcare inflation, the *Post* referred to a study in the February issue of *Health Affairs* examining an alliance in California similar to an ACO. The study concluded that if ACOs are able to exert more market power in negotiations, “private insurers could wind up paying more, even if care is delivered more efficiently.”

Under the reform law, an ACO would organize hospitals, physician and other providers into loose federations whose goal would be lowering costs,

not raising them. Participating providers would receive a portion of any Medicare savings they created. However, ACOs could also negotiate deals with private payors, who typically allow higher rates to larger organizations with greater leverage.

Normally, agreements between independent providers are illegal under federal laws, but federal enforcers are developing safe harbors for ACOs. The Federal Trade Commission and CMS sought input from hospitals, physicians and others on how ACOs should be accommodated in an information-gathering meeting in Baltimore on Oct. 5.

The *Health Affairs* article, written by researchers at the Urban Institute and the Centers for Studying Health System Change, was published before the healthcare reform law was passed and

argued for a different strategy than ACOs, based on the study’s findings. “Because antitrust policy has proved ineffective in curbing most provider strategies that capitalize on providers’ market power to win higher payments,” it stated, “policy makers need to consider approaches including price caps and all-payer rate setting.”

The *Washington Post* article focused on the effects of past and current hospital mergers on healthcare prices. Hospital mergers allow better access to capital for new services or equipment, such as electronic medical records, and a chance to prepare for ACOs. But the FTC has reported that some mergers caused prices to rise in some markets. After a 2000 merger of two Chicago-area hospitals, the federal agency in 2008 forced the two to negotiate with insurers separately. ■



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# 10 Tips to Creating a Physician-Led Integrated Care System With Advocate Health's Mark Shields

By Leigh Page

**A**dvocate Physician Partners has already stepped into the brave new world of integrated care, signing managed care contracts that assume risk. This loosely affiliated group of 3,700 physicians in the Chicago area includes 800 physicians employed by Advocate Health Care, which runs 10 hospitals. Here Mark Shields, MD, MBA, senior medical director of Advocate Physician Partners, shares some tips on forming such arrangements.

**1. Set up payor contracts.** Advocate Physician Partners manages a clinical integration pool, funded by commercial insurers, covering about 10 percent of physician fees that are distributed to physicians, provided they meet 116 system-wide clinical and efficiency goals, updated yearly. Last year, participating physicians earned \$4.9 million in the clinical integration program at just one Advocate hospital, Advocate Good Samaritan.

**2. Meet legal concerns.** When independent physicians negotiate payor contracts together, as occurs at Advocate Physician Partners, they are at risk of violating FTC prohibitions against colluding to set prices. Advocate Physician Partners can negotiate such contracts because it is integrated clinically and to a lesser extent financially, Dr. Shields says.

**3. Find out what payors want.** “We do a lot of talking with employers and insurers to determine what are the key concerns,” Dr. Shields says. “We focus on things that improve employee

productivity, such as treating depression, which is a major loss of function at work.” For example, heart surgery patients are at risk for depression. “It took a little bit of persuading to get our cardiologists to order a depression screening, but it has been a success,” he says.

**4. Create a culture.** For an integrated system to work, there has to be a culture of information-sharing and transparency. Dr. Shields says there needs to be a common business goal and physicians need to participate through a governance system. Safety has to be balanced with cost-effectiveness.

**5. Get physicians energized.** “Physicians need to drive the process,” Dr. Shields says. “This would be difficult for hospital executives who have bad relationships with physicians.” Dr. Shields urges communicating with practitioners. “Physicians need to understand the financial impact of what they are doing,” he says. Advocate uses training programs to get physicians up to speed.

**6. Create a chronic disease registry.** Disease registries clustered around diseases and conditions, such as asthma and diabetes, help physicians track key patient information. When registries are put on the Web, they can be tracked in real time. The registries are key because “chronic disease drives healthcare costs to a great extent,” Dr. Shields says.

**7. Perform patient outreach.** Patient outreach is crucial to efficient provision of care.

Advocate Physician Partners mails reminders to patients about upcoming visits and sends educational material and a telephone reminder. Each physician's office does the same.

**8. EHR not necessary.** While some health-care IT is needed for projects like the disease registry, Dr. Shields says an electronic health record is not needed to create the relationships and shared culture at the heart of an integrated system. Advocate is, however, installing an EHR.

**9. Provide more information for patients.** When insurance exchanges begin under health-care reform, more patients will opt for individual insurance, and providers will need to direct payor information to the consumer. “Patients expect information to be presented differently than how an employer wants it,” Dr. Shields says. For example, patients often don't understand the importance of measures like use of beta blockers or aspirin after a heart attack. Instead, they want more outcomes data.

**10. Shared savings will come.** Chicago-area payors are contemplating taking their payment arrangement with Advocate and creating shared savings approaches market-wide, but many local providers are not interested in this approach. “We have been told by consultants that some other systems in Chicago have no interest in clinical integration,” Dr. Shields says. “I feel that is shortsighted.” ■

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# 3 Medical Specialties Most Pursued for Employment by Hospitals

By Caitlin LeValley and Lindsey Dunn

**H**ospitals today are increasingly employing physicians for a variety of reasons, including the desire to gain more control over referrals and to be prepared for movement towards the accountable care model. However, some specialties are markedly more sought after than others. Primary care, cardiology and surgical specialties such as neurosurgery and orthopedics are particularly attractive.

**1. Primary care.** The impending move toward accountable care within the healthcare landscape is a strong reason for hospitals to enlist primary care providers. With ACOs, a core concept is that the ACO shares in savings with Medicare. To qualify to be an ACO, an organization must have 5,000 or more beneficiaries managed by primary care physicians. The primary care physicians will oversee the management of care and direct services. As such, many hospitals looking to develop ACOs are working to build up their primary care provider base.

John Narcross, a senior engagement manager with The Chartis Group, a healthcare consulting firm, says primary care physicians are a target because they serve as an entry point into the delivery system that hospitals will begin trying to create. Primary care includes traditional outpatient, hospital internists and family medicine, says Frederick T. Horton, president and CEO of Horton, Smith & Associates, a physician recruitment firm.

Janet Schwalbe, vice president of physician services at Gwinnett Medical Center in Georgia, echoes the importance of primary care providers to hospitals. "Looking at our community survey for Gwinnett, primary care is where the patient starts and that's where healthcare reform is moving." It's critical to reach out to primary care specialists and integrate them, she says.

Additionally, there is a growing general physician shortage, further increasing the demand to snap up physicians. Several national studies have indicated a shortage of 150,000 primary care physicians over the next 10-15 years. As a result, hospitals wishing to attract these physicians will have to offer competitive salaries. The average total annual compensation is \$232,553 for a family medicine physician and \$265,545 for an internal medicine specialist, according to data from the Delta Companies, a healthcare staffing firm. Given the primary care physician's direct power of referral, hospitals are increasingly interested in acquiring primary care providers who can then direct patients to the hospital's facilities.

**2. Cardiology.** Cardiology can be a big money-maker for the hospital since it is a high revenue specialty. As such, cardiologists are one of the first specialists hospitals are going after, says Chris Regan, a managing director with The Chartis Group. Fortunately for hospitals, cardiologists are increasingly leaving their private practices to join hospitals due to decreasing reimbursements. According to the American College of Cardiology, 30 percent of cardiologists surveyed said they have begun or have already integrated into a hospital. A great deal more are engaged in discussions to do so. These decreases are more easily absorbed by the hospital institution because employed cardiologists and cardiovascular surgeons generate significant revenue for the hospital. However, hospitals can expect to pay significantly more in salary to a cardiologist compared to other physicians. The average annual compensation for a cardiologist from June 2009 to June 2010 was \$583,750, according to data from the Delta Companies.

Additionally, cardiology is a critical specialty for hospitals looking to improve their clinical excellence and/or develop bundled payments. Both of these efforts are best achieved with aggressive integration actions, says

Robert A. Minkin, senior vice president with The Camden Group and former president and CEO of Exempla Saint Joseph Hospital in Denver.

**3. Neurosurgery and orthopedics.** Finally, there is a fair amount of demand for neurosurgery and orthopedics in the surgical category. "Neurosurgery is important for the medium- to- larger-sized hospitals as it is a significant revenue generator and is viewed as a premier service that can be an image booster," says Mr. Horton.

Ms. Schwalbe supports this trend, saying Gwinnett is planning to employ neurosurgeons. "There is a shortage of neurosurgeons and you must anchor them in your facility," she says.

Orthopedic specialists are also attractive to hospitals because their procedures pay well and will be on the rise as the population continues to age.

Marshall K. Steele, MD, CEO of Marshall Steele, a healthcare consulting firm, says his former orthopedic practice was recently purchased by a hospital and he strongly encouraged the move. "American healthcare has been all about independence for a long time, but now we need a culture of interdependence," says Dr. Steele. "Specialists bring the surgical patients with them to the hospital and it just makes total sense for both sides."

Neurosurgeons and orthopedic surgeons won't be cheap for a hospital to employ. The average annual compensation for neurosurgeons is \$571,000, according to 2010 data from Merritt Hawkins, a physician recruitment firm. Orthopedic surgeons employed by a hospital averaged \$404,210 in annual compensation, according to the Locum Tenens 2010 Orthopedic Surgery Salary Report. However, a recent study from Merritt Hawkins suggests an employed physician can generate revenue for a hospital in excess of 5-10 times his or her annual salary. ■

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# 10 Best Practices for Creating Hospital Group Practices

By Leigh Page

**T**odd Sagin, MD-JD, national medical director of HG Healthcare Consultants in Laverock, Pa., is coauthor of the book, “Creating the Hospital Group Practice: The Advantages of Employing or Affiliating with Physicians.” Here he offers some best practices for hospitals on organizing employed physicians into group practices.

**1. Form a multi-specialty practice.** Rather than allow each newly acquired practice to operate separately, Dr. Sagin prefers combining them in one large multi-specialty group that benefits from economies of scale. To function properly, he says such a practice needs at least 40 physicians. He thinks even a community hospital with a few hundred physicians on staff could reach this number by including hospital-based physicians as well as the practices it acquires.

**2. Keep the hospital at arms length.** Instead of making the group practice a subsidiary of the hospital, it should be a subsidiary of the parent health system on equal par with the hospital. Operating at arms length from the hospital, physicians can identify goals that go beyond inpatient admissions but still satisfy the mission of the health system. “Healthcare is becoming less about filling hospital beds,” Dr. Sagin says. “There need to be better drivers of overall healthcare goals.”

**3. Build a group practice culture.** Hospital-owned practices have failed in part because doctors didn’t like working under middle managers in the hospital. Dr. Sagin suggests creating a “group practice culture” in which physicians manage each other. Building such a culture requires setting expectations for membership and spending a great deal of time orienting physicians. The process can take six months to a year, he says.

**4. Acclimate physicians to new culture.** Hospitals typically pick up practices with only one, two or three physicians. “They had a great deal of autonomy,” Dr. Sagin says. “They have no history of being part of a group practice culture.” In the new group, they will have to share income, participate in governance and perhaps give up staff and move their locations. This involves an entirely different mindset.

**5. Create governance bodies.** The group practice should have its own governance system. Many decisions about structure need to be made. Will it have board or executive committee? Will members be elected or appointed? What accountability does it have to the health system board? There should be subcommittees for activities like finances, quality and practice culture. A full-time medical director can be added when the practice gets bigger. Since ex-

perienced medical directors are rare, this may involve grooming one of the physicians in the practice for the role.

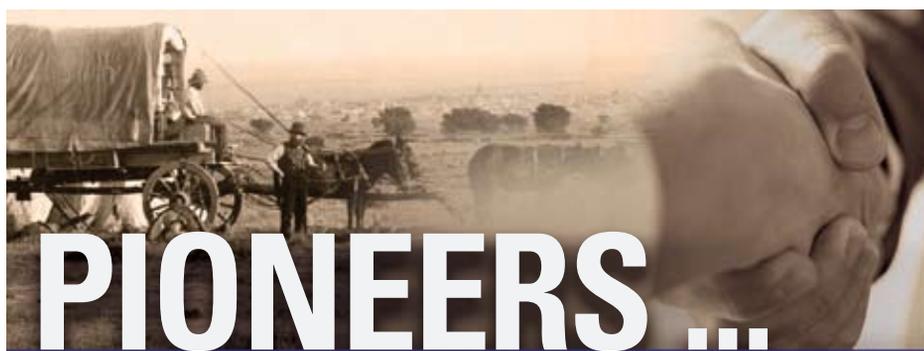
**6. Don’t make promises you can’t keep.** When hospitals guarantee salaries for several years or let physicians keep their staff or current location, the multi-specialty group’s hands will be tied. For example, the group may want to have its own centralized billing office or change locations. It may be able to get out of the commitments the hospital made, but not without leaving a bitter trail. “Physicians would feel there was a bait and switch to get them in,” Dr. Sagin says.

**7. Expect to pay a subsidy.** Under typical hospital accounting, a medical practice usually operates under a loss. Downstream revenue, such as physician referrals for ancillary services, is not included in practice earnings. “There needs to be some subsidy for the downstream revenue the practice makes for the hospital,” Dr. Sagin says.

**8. Don’t just pay for productivity.** Since payors no longer reimburse just for volume, neither should physicians be compensated just for volume. For example, if hospitalists are paid just for their productivity, they would simply see as many patients as possible. Instead, they should be incented to discharge patients as early as possible. This involves developing a fine-tuned payment system based on all expectations of the physician.

**9. Adjust pay for organizational activities.** If physicians are paid just for how many patients they see, they will avoid other important activities, such as meeting quality goals, participating in governance and helping to redesign care models. The compensation system should reward participation in these activities.

**10. Prepare for new payment models.** The physicians group should begin planning how it will shift reimbursements to bundled payments, shared savings in accountable care organizations and other arrangements coming up in the future but not quite here yet. The group can’t make such changes until payors alter payment methodologies, but they will have to have new systems in place and know when to implement them. “It will be a challenge to decide when to change,” Dr. Sagin says. ■



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# 7 Key Provisions for Successful Physician Employment Contracts

By Jaimie Oh

As hospital employment of physicians continue to increase due to uncertainties surrounding reimbursement and healthcare reform puts increasing emphasis on quality over quantity of care, it is becoming increasingly important for hospitals to create effective contracts for employed physicians that will not only result in maintained profitability but also quality care. Here are seven critical provisions for successful physician employment contracts.

**1. Obligations of the employed physician.** Contracts should include detailed descriptions of what exactly is expected of the employed physician. This includes detailing what type of medicine the physician will be practicing, hours the physician must be present at a location and any required on-call hours or administrative duties required.

“[Physicians] know they’re practicing medicine, but duties can involve certain hours of availability or when they’re at the hospital,” says Wayne J. Miller, JD, a healthcare transaction and regulatory attorney at Compliance Law Group in Thousand Oaks, Calif. “Sometimes, the physician may have to be on-call; some may have to provide outpatient care; and some may have administrative responsibilities or may be called on to practice in different locations.”

**2. Compensation agreement.** Hospitals typically no longer pay employed physicians just a flat annual salary. Instead, a physician’s base compensation will include extra bonuses tied to performance.

“Nowadays, a hospital will tie compensation to particular performance baselines or benchmarks. In other words, they look at how efficient the physician is with patients, how many patients they see in the course of a day or whether they meet certain quality and satisfaction measures based on patient surveys,” Mr. Miller says. “Compensation can also be tied to how well the physician helps the hospital reduce cost by using equipment and staff most efficiently.”

**3. Required training and/or peer review standards.** Not only should hospitals require physicians to be licensed and certified in their respective specialties, but they should also require them to demonstrate ongoing education and competency.

“A hospital may require a physician to go to conferences, seminars, review online materials periodically or might even want him or her to become active in an association,” Mr. Miller says.

In addition to demonstrating that an employed physician is credentialed and licensed, hospitals may require a minimum number of the physician’s cases to undergo peer review, which will be audited to ensure his or her professional competency.

“Surgery is a good example of how a hospital might require a minimum number of cases to demonstrate the surgeon is confident and competent,” Mr. Miller adds. “So not only does a physician have to meet basic credentialing requirements and maintain those, but the provision would also include being subject to peer review processes to evaluate their quality of care and if they are efficiently utilizing hospital staff and equipment.”

**4. Provider-payor agreement.** Employed physicians could be required to be participating providers with Medicare, Medicaid and other payors, Mr. Miller says. In those cases, hospitals could additionally require the physi-

cians to qualify in certain payment programs, such as PPO or HMO plans. Another critical provision related to qualifying physicians is assigning rights, where an employed physician assigns his or her right to payment to the hospital for any professional services rendered. This clarifies the hospital is receiving payments from payors, even though the physician is performing the medical services.

“With any payor that a hospital is contracted with, employed physicians must be a participating provider in, such as Medicaid, state Medicare program and any commercial payors,” Mr. Miller says. “Hospitals also want to make sure if it is participating in an HMO or PPO plan, they want that physician to qualify in the same status and arrangement with those payors as well.”

**5. Confidentiality and nonsolicitation agreements.** The confidentiality provision guarantees an employed physician will never disclose any confidential information — such as the hospital’s business procedures, patient lists and medical records — during and after his or her employment term. The nonsolicitation agreement ensures a physician will not solicit other employees of the hospital to work for them after he or she is terminated.

“If a physician has developed a relationship with other staff members, like a nurse, there’s typically a period of time after termination in which that physician cannot solicit to hire any of those staff members to work for him or her,” Mr. Miller says. “The key is that they cannot actively solicit and contact them to hire them.”

**6. Non-competition agreement.** In this clause, the employed physician cannot work for another competing hospital or healthcare facility in a capacity that will harm the business of the hospital. In most instances, these provisions are restricted by distance or a period of time, such as a 20-mile radius and up to one year following termination.

“Basically, a physician can’t go across the street and do the same kind of work that is competitive to the original employer because they don’t want their investment in the physician going to a competitor,” Mr. Miller says. “However, many states don’t allow for post-termination non-competition provisions because they say it’s a strain on the practice of someone’s profession. Most states would say a non-compete is permissible during the term of full-time employment.”

**7. Termination clause.** This clause specifies how long the contract is in place for. It is important hospitals outline probable causes or grounds of termination for terminating any one physician, such as poor performance, moral turpitude, substandard quality of care or lack of cooperation. This agreement could include a provision which allows the employed physician to self-terminate.

“To level the playing field, physicians can essentially create a mirror image of a laundry list of reasons that would allow them to self-terminate,” says Adam Kaufman, a business attorney practicing in negotiations of employment and independent contractor agreements. “That would include things like being assigned duties that are beyond the scope of normal expectations.” ■

# CMS Issues Stark Act Voluntary Self-Referral Disclosure Protocol — 9 Key Concepts

By Julie Ann Sullivan, JD, and Scott Becker, JD, CPA, McGuireWoods

The Patient Protection and Affordable Care Act requires the Secretary of the Department of Health and Human Services, with the Office of the Inspector General of HHS, to establish a protocol for healthcare providers and suppliers to disclose actual or potential violations of Section 1877 of the Social Security Act (the “Stark Act”). Under the Stark Act, healthcare providers and suppliers may not refer patients to any entity for certain services if the physician has a financial relationship with that entity unless an exception for such referral applies.

On Sept. 23, CMS released its self-referral disclosure protocol (SRDP). The SRDP provides guidance for healthcare providers and suppliers to self-report actual or potential violations of the Stark Act in exchange for potentially (although not guaranteed) informal and more lenient settlement proceedings. Providers and suppliers should be cautious in self-disclosing through the SRDP.

This article highlights nine key concepts and considerations regarding the SRDP.

**1. SRDP for Stark violations only.** CMS points out that the SRDP is only to address actual or potential Stark Act violations; if the disclosing party’s conduct raises potential liabilities under other federal criminal, civil or administrative laws, the provider or supplier should self-disclose through the OIG’s Self-Disclosure Protocol. If CMS reviews a SRDP and determines that other violations in addition to the Stark Act may be implicated, CMS will refer the matter to the appropriate law enforcement agency (i.e., the OIG or the Department of Justice).

**2. Conduct an internal investigation before filing a SRDP.** It is vital to conduct a thorough internal investigation of all related compliance issues prior to filing a SRDP because violations other than the one being reported that are discovered by CMS through the SRDP may be used by the appropriate government agency to bring charges against the disclosing party. Thus, it is important to have a full picture of all potential compliance problems or risks before opening the door to government scrutiny of an organization’s operations.

**3. Good faith cooperation necessary.** A SRDP must be made in good faith, meaning that a disclosing party that attempts to circumvent an on-going investigation or fails to fully cooperate in the self-disclosure process will be removed

from the SRDP, and as noted earlier, information learned in a SRDP that is terminated for any reason may be used by CMS or another law enforcement agency to pursue legal action against the disclosing provider or supplier.

**4. SRDP is distinct from the Stark advisory opinion process.** A disclosing party may not use the SRDP to obtain a CMS determination as to whether an actual or potential violation of the Stark Act occurred. A SRDP is only appropriate where the disclosing party is prepared to accept responsibility for a violation or potential violation of the Stark Act and is prepared to work with CMS to come to a resolution regarding such violation.

**5. Participation in SRDP conditioned on certain terms; waiver of appeal rights.** One condition of disclosing a matter pursuant to the SRDP is that the party waives all appeal rights attached to claims relating to the conduct and agrees to have the reopening rules (i.e., rules pertaining to remedial actions to change a final determination that resulted in either an overpayment or an underpayment) apply from the date of the initial disclosure to CMS. Similarly, although CMS has the authority to reduce the overpayment amount owed by the disclosing party as a result of the Stark violation, CMS has no obligation to reduce any amounts due and owing. As CMS states:

CMS will make an individual determination as to whether a reduction is appropriate based on the facts and circumstances of each disclosed actual or potential violation. The nature and circumstances concerning a physician self-referral violation can vary given the scope of the physician self-referral law and the health care industry. Given this variability, CMS needs to evaluate each matter in order to determine the severity of the physician self-referral law violation and an appropriate resolution for the conduct.

CMS further advises that “a disclosing party should make a submission to the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified.”

**6. Other discovered violations in CMS verification process of SRDP fair game.** Any matters uncovered during CMS’s verification processes and investigation pursuant to the SRDP which are outside of the scope of the matter disclosed to CMS may be treated as new

matters outside of the SRDP and prosecuted accordingly. In other words, self-reporting a Stark Act violation could potentially lead to additional criminal, civil or administrative liabilities under statutes such as the False Claims Act or the Anti-Kickback Statute.

**7. Need to act quickly.** Given the 60-day time limit to return or report potential overpayments pursuant to Section 6402 of PPACA, providers and suppliers need to act quickly in order to get a SRDP on file if the provider or supplier believes he or she has violated the Stark Act or has potentially violated the Stark Act. Note, however, that the 60-day period to return or report overpayments is tolled once a valid SRDP is filed.

**8. Complex disclosure requirements.** The SRDP submission is a tedious process requiring complete legal and financial analyses related to the violation or potential violation. Some of the components of the SRDP submission include:

- A detailed description of the actual or potential violation, including a complete legal analysis of the application of the Stark Act to the conduct and any exceptions to the Stark Act that may apply;
- A description of all past, present and future compliance programs that the disclosing party has implicated, why such programs failed in preventing the violation, and what efforts have been taken to avoid violations going forward;
- A detailed financial analysis of the violation, itemized by year, for the entire period of non-compliance (referred to by CMS as the “look back” period), as well as a description of the methodology used for the financial analysis; and
- Certification by an authorized representative of the disclosing party that all information contained in the SRDP is truthful and based on a good faith effort to bring CMS’s attention to the Stark Act violation.

**9. Secure appropriate representation and counsel.** Because a SRDP is a tedious process involving careful legal and financial analyses of a provider or supplier’s business, providers and suppliers are urged to seek immediate counsel if they suspect they have violated the Stark Act. ■

# OIG's Increased Scrutiny on Heart Stents and ICDs: What It Means For Your Hospital

By Lindsey Dunn

In the past two years, the federal government has greatly increased its efforts to combat Medicare and Medicaid false claims and fraud by healthcare providers. In May of 2009 Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius announced the creation of a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team, to combat fraud. In addition, the new Patient Protection and Affordable Care Act, which became law in March, boosts funding for fraud investigation and enforcement by \$300 million over the next 10 years and provides additional tools and oversight to investigators.

“From the regulatory agency viewpoint, we’re seeing unprecedented efforts by agencies to coordinate their activities,” says Bo Martin, PhD, CFE, CAMS, a statistician with Navigant Consulting. “HHS’ Office of Inspector General, the Department of Justice and state agencies are working together in a very coordinated fashion, which is very impressive compared to their previously siloed approaches.”

## ICDs increasingly a focus of investigations

One area of possible fraud that has come under recent scrutiny by the OIG and other regulators is the implantation of heart stents, ICDs (implantable cardioverter-defibrillators) and pacemakers. A recent case that has made headlines across the country is an investigation into the stent implantation rates of cardiologists at St. Joseph Medical Center in Towson, Md. Analysis of patient records found that cardiologists at the hospital performed stent procedures at rates well above the state average (roughly 30 percent of patients undergoing catheterization receive a stent) and, in some cases, more than double the average rate. The hospital argued that it sees more complicated cases as a regional referral center and therefore, above average stent rates are to be expected. Although neither the hospital nor the physicians have yet to be charged with wrongdoing, the case is reflective of a move by government regulators to make the examination of ICD and stent rates an increasingly significant area of investigative focus.

“Cardiology and the implantation of ICDs is a very lucrative area for hospitals,” says Phil Hurd, MHA, CPC, CCP, a director in the healthcare practice at Navigant Consulting. “It appears [the regulators] believe that some of these procedures were not medically necessary, and regulators have really begun to focus on these procedures.”

In recent months, several hospitals across the country have reported receiving investigative demands for various documents related to these procedures, including patient charts and claims data, from the OIG. While it remains unclear just how many hospitals have received the request, Tenet Healthcare Corp., which operates 49 acute-care hospitals in 11 states, recently disclosed that one of its facilities received a request from the DOJ for documentation on ICD implantations going back to 2002. Tenet said in its disclosure that it expects similar requests at more of its facilities in the coming months.

During these investigations, regulators examine whether or not the hospital has documentation supporting the medical necessity of the claims. Medicare’s National and Local Coverage Determinations outline the specific instances when ICDs and other implants, such as stents, can be billed to the program. For example, any ICD implanted in patients and billed to Medicare must include specific documentation showing the patient meets

the determinations for coverage, including copies of relevant tests and diagnostics. “Hospitals are at risk if they do not have a complete history documenting the patients’ medical condition,” says Mr. Hurd. “Some tests are performed in the physician office or a free standing diagnostic center, which makes it even more challenging for hospitals.” Thus, hospitals lacking adequate documentation could face false claims and fraud charges, even if the claims were unintentionally false.

## Will your hospital be targeted?

It seems clear that the OIG has increased its scrutiny of ICD and stent procedures, and hospitals with unusually high levels of these procedures, which can be identified with data mining of Medicare claims data, are likely to be targets of investigation. “A hospital with high rates of implantations may not necessarily be non-compliant. Regional referral centers and cardiac centers of excellence will likely have higher rates due to higher acuity cases,” says Kristofer Swanson, CPA, CFE, CFF, CAMS, managing director in the Dispute Resolution, Forensic Accounting & Regulatory Compliance practice at Navigant Consulting. “However, high rates could prompt an investigation, the results of which could be good or bad for the hospital.”

Mr. Swanson recommends that hospitals take a proactive approach in determining their level of risk. “Once a government investigation starts, the pressure on the institution increases dramatically,” he says. “It’s much better to lean forward thoughtfully now and determine if the hospital appears to be an outlier, and if it does, have the opportunity to gather supporting documentation and conduct analysis, without the increased strain of a concurrent investigation.”

## What hospitals should do now

**1. Determine if your hospital has high rates of implantation compared to peers.** Hospitals should begin by having a clear understanding whether or not they are likely to be targeted with an investigation, which means examining whether or not the hospital’s rate of implantation is higher than state and/or regional averages. These analyses, which typically use MEDPAR data, are often performed by an outside firm and serve only as “red flags” for a possible investigation, not an indicator of actual fraud as implantation rates may vary by hospital for a variety reasons, including those discussed in the above section.

“Hospitals can assess if they are likely to show up on the government’s radar screen by examining how the hospital compares to an aggregate of other facilities in the state,” says Mr. Martin. “Regulators and RACs (Recovery Audit Contractors) are mining this data as we speak, so hospitals should do so as well to understand whether or not they are likely to trigger interest from regulators.”

**2. Examine a sample of claims on a provider-by-provider basis for compliance.** In addition to examining aggregate implantation rates, hospitals should examine a sampling of individual claims to ensure they are compliant. “A hospital, when examined by total claims, might not show up on the radar, but certain physicians could be putting the hospital at risk,” says Mr. Hurd. “Hospitals need to examine claims for provider variability and possible fraudulent activity on a doctor-by-doctor basis.”

Mr. Swanson recommends hospitals bring in coding and compliance experts to examine several hundred implant claims from all physicians per-

forming those procedures. During this process, the examiners review all files for necessary documentation to establish medical need.

**3. Locate any missing documentation and/or seek legal guidance.** If hospitals determine patient files are missing documentation, which essentially renders the claims false, they should immediately begin to gather that documentation by working with the physician, his or her office and any relevant outpatient facilities. This step affords hospitals the opportunity to ensure each patient has a complete medical re-

cord and is more cost-effective than waiting until regulators come knocking, says Mr. Swanson. At this point, hospitals may also choose to seek legal guidance, especially if documentation cannot be located to support the claim. In this type of situation, a hospital may decide to voluntarily self-report to regulators.

**4. Improve upon any processes that put the hospital at risk.** Hospitals can also use a self-analysis as an opportunity to implement process improvements that address any issues that appear to put the hospital at risk. “Hospitals

not only need guidelines that ensure compliance, but they also need to make sure they are adhered to,” says Mr. Hurd. For example, hospitals can set “roadblocks” to ensure procedures do not occur unless the patient’s record contains all necessary documentation and the patient is qualified for the procedure, according to Medicare’s determinations.

“You can gain valuable insight from an arm’s length analysis that will improve your program and your patients’ care going forward,” says Mr. Swanson. ■

## Government to Intervene in Mayo Clinic False Claims Investigation

By Jaimie Oh

**T**he Department of Justice will be joining a lawsuit against Mayo Clinic, based in Rochester, Minn., which has been accused of submitting fraudulent claims to Medicare and Medicaid for pathology tests that were never performed, according to a *Pittsburgh Tribune-Review* report.

The lawsuit, filed by former Mayo patients, survivors of deceased Mayo patients and a Minnesota attorney, accuses Mayo of billing federal healthcare programs, including Medicare and Medicaid, for pathology tests that were never rendered. Records show Mayo billed Medicare for permanent specimen slides and examination of those slides, even though no such slides were prepared or examined, according to the report.

The lawsuit against Mayo claims it instead prepared only frozen section slides that were not retained. Federal law and regulations require medical facilities to retain pathology slides for 10 years, according to the report.

The DOJ will only join one of four claims in the lawsuit, which involves billing federal healthcare programs for tests that were not performed. After the DOJ filed its notice of intervention, a U.S. district judge partially lifted a seal that kept details of the case private for three years, according to the report.

A spokesperson for the Mayo Clinic stated it has fully complied with the law, saying Mayo discovered the billing error in 2007 and voluntarily refunded \$242,711 before the system was aware the government was considering becoming involved in the unsealed complaint. ■

## California’s El Centro Regional Medical Center to Pay \$2.2M to Settle Medicare Fraud Allegations

By Jaimie Oh

**E**l Centro Regional Medical Center, located in Imperial County, Calif., has agreed to pay \$2.2 million to the government to settle Medicare fraud allegations, according to the Department of Justice.

The government accuses the medical center of inflating charges for services provided to Medicare patients in order to receive larger reimbursements from the federal healthcare program. The claims submitted by the facility were for short inpatient admissions when, in fact, the services should have been billed on an outpatient “observation” basis or as emergency room visits, according to the report.

The alleged Medicare fraud was brought to light by Pietro Ingrande, a former employee of the medical center. Mr. Ingrande will receive \$375,000 under the qui tam, or whistleblower, provisions of the False Claims Act, which permit private citizens with knowledge of fraud against the government to bring an action on behalf of the United States and share in any recovery. ■

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## 18 Florida Hospitals Under Investigation for Improper Medicaid Billing

By Lindsey Dunn

**F**lorida Attorney General Bill McCullom is investigating 18 hospitals throughout the state for improper Medicaid billing of emergency services, according to a *Miami Herald* report.

Hospitals under investigation include Jackson Memorial Hospital, Baptist Hospital, Miami Children's Hospital, all located in Miami, and Homestead (Fla.) Hospital, Memorial Regional Hospital in Hollywood, Fla., and North Broward Medical Center in Pompano Beach, Fla. Three hospitals have already settled with the state. St. Joseph's Hospital in Tampa, Fla., Lakeland (Fla.) Regional Medical Center and All Children's Hospital in St. Petersburg, Fla., agreed to pay a combined \$566,004 to settle the investigation without admitting any wrongdoing.

The investigation is looking specifically at Medicaid payments for patients in the ER that don't truly need emergency treatments. While specific details of the investigation were not released, a spokesperson for the Medicaid Fraud Control Unit said the investigation deals with possible false claims for Medicaid payments related to "screening and/or non-emergency services," according to the report.

The investigation is taking place at the same time 10 Florida hospitals have legally challenged the state's Agency for Health Care Administration, alleging it is improperly denying payment for outpatient-type services provided in the ER, according to the report. ■

## Georgia's WellStar Health System Settles Medicaid Billing Investigation for \$2.7M

By Lindsey Dunn

**M**arietta, Ga.-based WellStar Health System has agreed to pay the state of Georgia nearly \$2.4 million to settle a Medicaid billing investigation for both inpatient and outpatient services at five WellStar hospitals — Cobb Memorial Hospital, WellStar Kennestone Hospital, WellStar Windy Hill Hospital, WellStar Douglas Hospital and WellStar Paulding Hospital, according to a news release by Georgia Attorney General Thurbert E. Baker.

The settlement follows a six-month investigation by the Georgia Medicaid Fraud Control and the Department of Community Health into WellStar's billing for "cross-over" claims, which are claims made for patients who are enrolled in both Medicare and Medicaid. Medicare acts as the primary coverage, with Medicaid functioning as the secondary insurance, and Medicaid has a cap on the amount of reimbursement that a hospital can receive. The investigation suggested that WellStar filed claims which did not reflect the full amount of Medicare prior payments, allowing WellStar to receive excessive Medicaid reimbursements.

Under the terms of the agreement, WellStar and its hospitals denied any wrongdoing, but agreed to pay the Georgia Department of Community Health a lump sum of \$2,728,318 to settle all possible claims related to the billing errors. WellStar also agreed to pay the state \$10,000 to defray the costs of its investigation. WellStar cooperated fully with the investigation and implemented corrective actions to ensure that similar billing problems do not reoccur, according to the report. ■

## New York's North Shore-Long Island Jewish Health System Settles Fraud Investigation for \$2.95M

By Lindsey Dunn

**N**ew York's North Shore-Long Island Jewish Health System has agreed to pay \$2.95 million to settle an investigation following a civil claim alleging the hospital submitted fraudulent bills to Medicare,

according to a *Wall Street Journal* report.

The case alleged the system billed Medicare between 1994 and 2001 for costs it did not incur. The case further alleged these costs were associated with a private physicians offices and a

pre-school, according to the report. No further details were given.

The health system admitted no wrongdoing but agreed to settle to avoid litigation costs, according to the report. ■

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# 10 of the Biggest Hospital and Health System Transactions of 2010

By Caitlin LeValley

Here are 10 of the biggest hospital and health system transactions in the United States so far in 2010.

**1. Vanguard Health System, Nashville, Tenn. — \$1.5 billion, September.** The Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice have cleared Vanguard Health System's \$1.5 billion acquisition of Detroit Medical Center, granting early termination of a 30-day pre-merger waiting period.

**2. Caritas Christi Health Care, Boston. — \$830 million, March.** Boston-based non-profit Caritas Christi Health Care agreed to be acquired by New York private equity firm Cerberus Capital Management. The Massachusetts Supreme Judicial Court held hearings through July 1.

**3. Detroit Medical Center, Detroit. — \$417 million, June.** Vanguard Health Systems plans to buy eight-hospital Detroit Medical Center, Michigan's largest healthcare system, and spend \$850 more in improvements over the next 15 years. The groups hope to finalize by Nov. 1.

**4. Prospect Medical Holdings, Los Angeles. — \$205 million, August.** Prospect Medical Holdings, a Los Angeles-based managed care provider, which operates five hospitals, agreed to be acquired by Leonard Green & Partners, a private equity firm and members of the company's own management team.

**5. Sumner Regional Health Systems, Gallatin, Tenn. — \$156.8 million, September.** LifePoint Hospitals finalized its acquisition of Gallatin, Tenn.-based Sumner Regional Health Systems for the cash price of \$156.8 million.

**6. Wuesthoff Health System, Rockledge, Fla. — \$145 million, July.** Rockledge, Fla.-based non-profit Wuesthoff Health System agreed to sell its assets to Naples, Fla.-based Health Management Associates.

**7. Forum Health, Youngstown, Ohio. — \$120 million, August.** A U.S. Bankruptcy Judge approved the sale of Youngstown, Ohio-based Forum Health to Community Health Systems.

**8. IASIS HealthCare, Franklin, Tenn. — \$95 million, September.** Franklin, Tenn.-based IASIS Healthcare announced an agreement to purchase Brim Holdings of Brentwood, Tenn., for \$95 million.

**9. Clinton Memorial Hospital, Wilmington, Ohio. — \$82 million, May.** Brentwood, Tenn.-based RegionalCare Hospital Partners acquired Clinton Memorial Hospital. RegionalCare has agreed to invest an additional \$75 million for capital expenditures and physician recruitment over the next ten years.

**10. Bert Fish Medical Center, New Smyrna Beach, Fla., — \$71 million, July.** Bert Fish Medical Center merged with Orlando-based Adventist Health System. Adventist will take over the operations of Bert Fish as part of a five-year lease agreement. ■

## Is a Statutory Hospital Merger a Bona Fide Sale?

By Hedy S. Rubinger & Diana Rusk Cohen, Arnall Golden Gregory LLP

### Recent Cases Demonstrate that the Deal's Financial Structure Is Critical

The regulatory status of a statutory merger between hospitals can have significant financial ramifications. The Code of Federal Regulations (42 C.F.R. § 413.134(f)) allows realization of gains or losses from the disposition of depreciable assets on a merged entity only if the merger qualifies as bona fide sale. Hospital mergers do not always meet this important criterion.

In *St. Luke's Hospital v. Sebelius*, the U.S. District Court for the District of Columbia held that the Centers for Medicare and Medicaid Services Administrator properly determined that a statutory merger between hospitals was not a bona fide sale because the acquired entity did not receive reasonable consideration for its assets. [1] Based on this decision, the surviving entity in the St. Luke's merger has not been able to claim a Medicare loss for the merged entity's \$2.9 million in depreciable assets. [2]

However, in *UPMC-Braddock Hospital v. Sebelius*, the U.S. Court of Appeals challenged a District Court holding that a hospital merger was not a bona fide sale.[3] In UPMC, as in St. Luke's, a key factor in the District Court's decision was that the transaction lacked reasonable consideration. The District Court noted that the surviving entity received \$26 million in assets and \$13 million in liabilities and that the large difference between the figures cast doubt on whether the merger involved a bona fide sale.

On appeal, UPMC argued that the \$26 million asset figure was inaccurate due to overvalued real estate and buildings, and was in fact closer to \$16 million. According to this assessment, the difference between assets and liabilities was much smaller than what the District Court had assumed when it decided to deny the depreciation claims. The appellate court held, based on the reduced asset figure, that the consideration could be reasonable. Third Circuit remanded the case back to the District Court to determine whether a bona fide sale occurred based on the revised figures.

As these cases demonstrate, hospitals and other health entities need to consider the regulatory ramifications of mergers, consolidation and other forms of ownership transfer. CMS and its intermediaries will decide how to handle certain claims from merged entities based on the merger's regulatory status. In St. Luke's and UPMC, the mergers' underlying financial structures played a significant role in the CMS determinations and court holdings. Healthcare entities should consider such cases when structuring a merger. ■

#### Footnotes:

[1] No. 08-0883 (D.D.C. Sept. 30, 2009).

[2] St. Luke's Hospital has appealed this case to the D.C. Circuit and oral arguments are set for early May.

[3] (CCH) ¶1303,275 (3rd Cir. Jan. 20, 2010).

# 4 Ways Community Hospitals Can Align With a Health System, Short of Acquisition

By Leigh Page

For about eight years, Spectrum Health in Grand Rapids, Mich., has led a loose regional network of 21 community hospitals. The stated purpose of the organization is to preserve the independence and economic strength of community hospitals in the region. Currently 14 member hospitals are independent facilities while the rest are owned by Spectrum. Members pay dues, which the organization won't specify. Here John Mosley, senior vice president for strategic development at Spectrum Health, lists four ways in which community hospitals benefit by aligning with a large health system, short of acquisition.

**1. Clinical quality programs.** The Spectrum Health Regional Hospital Network, a not-for-profit organization, can undertake almost any kind of clinical quality program, such as application of best practices, shared safety expertise and dashboards for clinical and safety outcomes. The network is now working on lowering readmissions for congestive heart failure. "It's a two-way street," Mr. Mosley says of the 3,100 licensed-bed partnership. "We provide our information to them, but we also learn from their information."

**2. Purchasing.** Mr. Mosley says membership in the network provides savings well above what members pay in dues. Members work together to standardize use of products, but they can also opt out of a particular initiative. In its first four years, the network saved more than \$10 million in medical-surgical, pharmacy and laboratory supplies, and it improved access to mobile MRI services for participants.

**3. Exchange of ideas.** CEOs of each hospital of the regional network meet quarterly. At the last meeting, the group discussed how to develop a risk-management program. In addition, directors of departments like purchasing and clinical quality and safety meet regularly. There are standing councils on clinical quality, human resources, information technology, Joint Commission readiness, laboratory services, pharmacy services, physical therapy and rehabilitation therapy, purchasing and radiology.

**4. Access to expertise.** Spectrum can also serve as a kind of consultant, charging an extra fee at a fair market value for its services. The services it offers members of the network include help with billing, certificate of need applications, build-

ing projects, real estate services, HIPAA compliance, government affairs and philanthropy.

**What cannot be shared.** Mr. Mosley says a network of independent hospitals is legally prohibited from sharing access to capital, employee benefits, strategic planning, legal counsel, managed care contracting or any form of pricing or reimbursement.

**Benefits for Spectrum.** In addition to sharing quality information and enhancing its purchasing power, Spectrum can improve relationships with community hospitals through the network. "We want to build trust," Mr. Mosley says.

This is important because some community hospitals are said to be wary of Spectrum's dominance of the region. In July, Northern Michigan Regional Health System in Petoskey, Mich., which is not part of the network, ended merger talks with Spectrum. Meanwhile, Gerber Hospital in Fremont, Mich., which is a member of the network, recently agreed to be acquired by Spectrum, and Spectrum is in merger discussions with Zeeland (Mich.) Community Hospital, another member of the network. ■

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## Boston's Caritas Christi to Close Two Hospitals if Cerberus Deal Fails

By Lindsey Dunn

Executives from Boston-based Caritas Christi Health Care have said the system will close two hospitals — St. Elizabeth's Medical Center and Carney Hospital, both in Boston — if its deal to be acquired by private equity firm Cerberus Capital Management is not completed, according to a *Boston Globe* report.

The announcement was made as the six-hospital health system negotiated a new contract with the Massachusetts Nurses Association. Caritas Christi said the closures would be required to gain control of financial losses. The health system asked the nurses to accept a wage freeze, but no agreement has been reached.

Cerberus Capital and non-profit Caritas Christi announced their deal in March. They are currently awaiting approval from the Massachusetts Supreme Judicial Court. ■

## Florida's Broward Health Plans to Transition to New Community Not-for-Profit Corporation

By Caitlin LeValley

The board of commissioners of the North Broward Hospital District has voted to authorize Broward Health President and CEO Frank Nask to coordinate the transition of the Fort Lauderdale, Fla.-based healthcare system to a new community not-for-profit corporation, according to a Broward Health news release.

By allowing a not-for-profit corporation to manage daily operations, Broward Health will be able to pursue opportunities such as joint ventures and expansion of services to generate additional funds. "This resolution is a proactive response to impending changes in our operating environment brought about by federal healthcare reform," said Mr. Nask in the release.

The Board has scheduled four public workshops to discuss strategic planning matters and welcome public opinion related to the transition to a community not-for-profit corporation. The first meeting is scheduled for Wednesday, Sept. 29. ■

## University of Michigan Health, Two Other Systems Launch Pennant Health Alliance

By Lindsey Dunn

Grand Rapids, Mich.-based Metro Health, Novi, Mich.-based Trinity Health and University of Michigan Health System, based in Ann Arbor, have joined together to launch Pennant Health Alliance, according to a U of M Health news release.

The new support-services network will initially offer clinical support and administrative services in four key areas: physician alignment and recruitment, health information technology, revenue cycle management and group purchasing. Other

customized services, such as quality consulting and performance reporting, will be available on an as-requested basis, according to the release.

All U of M Health and Metro Health facilities as well as Trinity Health's West Michigan hospitals, which include Mercy Health Partners' in Muskegon, Mich.; Saint Mary's Health Care in Grand Rapids; Battle Creek (Mich.) Health System; Mercy Hospital – Cadillac (Mich.) and Mercy Hospital – Grayling (Mich.) will join the alliance.

Mike Faas, president and CEO of Metro Health,

has been named CEO of the alliance.

Hospital and physician practices are welcome to join the alliance through support services agreements, according to the report.

Holland (Mich.) Hospital has watched the alliance "with interest," according to the report, and Traverse City-based Munson Healthcare called off merger talks with Spectrum Health System last week, after being offered a partnership opportunity with U of M Health, according to a *Grand Rapids Press* report. ■

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# 8 Ways Hospital Executives Can Increase Their Earning Power

By Laura Miller

**H**ere are eight ways hospital executives can advance their careers and increase their earning power.

**1. Continue education.** Hospital CEOs and administrators must have an advanced degree in their specialty area before advancing their career, says Doug Smith, MBA, MHA, President and CEO of B. E. Smith. “When employers are looking at credentials, there are several things they will check,” says Mr. Smith. “Your master’s degree is the minimum requirement and then you need to stay educated from that point on.”

Administrators can continue their education through advanced non-credit course hours at the graduate level. Courses in emerging technology and management practices are particularly attractive to employers. “It’s a competitive advantage to embrace technology,” says Don Rottman, president of The Rottman Group. Administrators can also take advantage of training offered by professional societies to show they are serious about job advancement.

**2. Network among peers, competitors and recruiters.** Actively networking can be difficult for administrators to fit into their busy schedules, but is crucial for advancing their careers. “The people who find work the quickest are people who have a well developed professional network,” says Mr. Rottman. “Unless you’re in an environment that is a multiple hospital [system], to continue to grow, you will most likely have to go somewhere else for continued career advancement.”

Hospital executives should attend association conferences and connect with mentors in order to position themselves as future industry leaders. The American College of Healthcare Executives provides networking activities that could be useful when searching for jobs in the future. Mr. Smith says it is also important to network with competitors and recruiters during all career stages. “You never know where your next job is going to come from,” says Mr. Smith.

**3. Move with the job.** It may be necessary to switch locations in order to earn a promotion, which can be tough for administrators with families who would rather stay put. However, Mr. Smith says administrators must be open to moving for a better job. “You have to seize the moment when an opportunity comes your way,” says Mr. Smith. “When a good opportunity comes along, you have to grab it and go.”

**4. Take an initial pay cut.** In some situations, hospital executives can benefit from leaving their position at a larger hospital to fill a higher leadership role at a smaller facility. Working at a smaller hospital gives the administrator additional experience in a broader leadership role, which can be used as a springboard to their next job in a larger hospital. However, transferring from a large hospital to a small hospital often means taking an initial pay cut. “A lot of times clinical leaders can be making a significant amount of money, but in order to work into senior administration they might have to take this pay cut,” says Mr. Smith. “Sometimes you have to be willing to take a little less money for a long-term gain.”

**5. Invest in the employees under you.** Executives should work well with those under them, allocate leadership positions and encourage their employees to grow within their careers. This means administrators should accept turnover when it happens. “People in leadership roles should actively develop the people under them. They could become your replacement when you leave, or could themselves leave for an advancement opportunity. Either way, it speaks to your quality leadership competencies,” says Mr. Rottman. “If you find yourself looking for a job, these people also become your greatest networking advocates.” Additionally, administrators who can show their ability to develop and prepare their employees for better opportunities are more attractive to potential employers.

**6. Display the characteristics of the job you want.** Hospital administrators can show their employers they are promotable by taking on challenges and responsibilities similar to those required for the position. “A lot of individuals are trying desperately to prove themselves in the job they have but they also have to behave in a way that shows they are promotable,” says Mr. Smith. “As you grow your career and you look to make changes, you need to behave like one would in order to get that job.” Promotable behaviors include the ability to draft ideas, contribute during presentation discussions, handle leadership or authority positions well and wear appropriate attire.

**7. Present in front of an audience.** One of the best ways for hospital leaders to network and display promotable behavior is to give presentations either at the hospital or at organization conferences. Giving professional presentations allows the administrator to show he or she

is able to make a logical argument and convince others to go along with his or her program. Administrators who speak publicly are also seen as leading experts on their topic.

**8. Develop programs with incremental outcomes.** Administrators need to document the before, during and after effect of their tenure by benchmarking the changes they’ve influenced. Future employers are more impressed with administrators who are able to articulate the positive changes they made in their previous or current position. “To convince someone you would be of value to them, you have to be able to show how you’ve been of value to others,” says Mr. Rottman. “If you are above average, why? Be able to articulate the incremental value you’ve had on an organization. People who can quantify things really stand out.” ■

## Physician Incentive Plans on the Rise

By Rachel Fields

**A**nnual performance-based incentive plans are on the rise for physicians in both presence and scale, according to Hay Group’s recently released *2010 Physician Compensation Survey*.

In 2010, 63 percent of hospitals offered physician incentive plan, up from 51 percent in 2009. Ninety-two percent of group-based organizations now offer incentive plans to physicians, up from 75 percent in 2009. Of the 28 healthcare organizations who responded to the survey saying they had no physician incentive plans, 39 percent said they were considering them.

The survey also showed a 2.9 percent base salary increase for 2010-11 compared to a 2.8 percent increase in 2009-10. Group-based physician practices, which offered higher increases of 4.8 percent in 2009-10, reported base salary increases of only 3.3 percent for 2010-11. ■

# 4 Trends in Non-Profit Hospital Executive Compensation Over the Next 5 Years

By Rachel Fields

Every week, the healthcare industry sees headlines about hospital executive compensation controversy — how much CEOs are making, who decides it and whether the pay is reasonable. As hospitals struggle to stay financially viable, executive compensation practices will demand more oversight and data measurement to ensure hospital leaders are paid what they deserve. William Quirk, national director of healthcare consulting for Hay Group, discusses four ways executive compensation is changing as the effects of healthcare reform loom on the horizon.

**1. Almost every hospital in America will use an executive incentive plan.** According to Mr. Quirk, around 90 percent of hospitals in America today use incentive plans, compared to almost zero in the early 1980s. And rather than shy away from incentive plans that might penalize bad behavior, hospital executives are growing more and more enthusiastic about the chance to prove their worth and make money based on real progress.

Incentive programs are effective in part because they allow a hospital to diminish compensation without touching base salary. “We see frozen salaries, but we don’t see diminished salaries,” Mr. Quirk says. “We just see incentives that don’t pay out if goals are not achieved.” This means the executive is almost entirely responsible for his or her compensation increases or decreases — except in a situation where the hospital is financially unstable and cannot pay the incentive. Giving the executive responsibility for maintaining a high-quality hospital will be essential as the government introduces stricter regulations on quality patient care and readmissions.

**2. Long-term incentive plans will become more important.** As the effects of healthcare reform on hospitals become clearer, long-term incentive plans that focus on strategic direction will be essential, Mr. Quirk says. “Going forward, hospitals will have to ask, ‘Can we really be all things to all people? Do we need to stick to acute-care rather than branching out into exotic programs?’” he says. “With reimbursement going down, hospitals are going to have to be careful about picking the right focus and making sure they implement it correctly.”

Unlike short-term incentive programs, which might focus on annual goals such as improving annual operating efficiency, long-term incentive programs focus on loftier goals that are accomplished over the span of many years. These goals depend on the hospital’s strategic direction, and might include measures like improving patient satisfaction from the 40th percentile to the 80th percentile or building a new cancer center. Because non-profit hospitals don’t have the option of offering stock options as long-term incentives, executives are incented with a percentage of their salary. If a CEO is making \$100,000 per year, he or she might be incented on a short-term basis at 30 percent of that base salary to meet annual goals. For long-term incentive programs, that percentage is multiplied by the number of years, so a three year incentive program would compensate the CEO at an extra 90 percent of his or her base salary.

Long-term incentive programs will become more important as hospitals look several years ahead to plan for major changes. For example, a hospital that plans to meet meaningful use requirements might incent its CEO on a long-term basis to effectively implement an EMR.

**3. Incentives will focus on true areas of need rather than areas that are already strong.** For an incentive plan to work, hospital boards have to sit down and examine the real failures at their hospital. Mr. Quirk says if a hospital is at the 93rd percentile for physician satisfaction, they should stop incenting hospital executives to increase that number. “Statistically, it’s not going to happen,” he says. “Once you reach your target achievement level in the incentive plan, find something else you need to work on.”

As data management systems become more widespread, hospitals have the option to measure many different metrics to determine compensation. “If your cost per discharge is at the 80th percentile of teaching hospitals in America, you have to get that number down, and the incentive program might help with that,” Mr. Quirk says. Track data over time and use it to find your areas of weakness, whether they lie in patient satisfaction, physician satisfaction, FTEs per occupied bed, infection rates or any number of other metrics.

**4. Perks will become less and less common.** Already, the healthcare industry has almost done away with perks unrelated to job title, Mr. Quirk says. Unlike in the 1980s and 1990s, when executives might receive private helicopter use and first class air fare for spouses as part of their compensation package, healthcare executives are now usually only offered business-related perks. “If there’s a country club membership and it’s used for business, the percentage the CEO uses for business can be taken off taxes,” Mr. Quirk says. “Spouses are still encouraged to attend professional association meetings, but it’s all work-related. Private helicopters, Lear jets — that doesn’t exist in not-for-profit healthcare.” ■

## 10 Statistics About Compensation of Healthcare Executives

By Rachel Fields

Here are 10 statistics about compensation of healthcare executives, based on 2009 data, according to the *2009 AMGA Medical Group Compensation and Financial Survey*.

1. Median compensation of non-physician CEOs in healthcare organizations was \$259,302 in 2009.
2. Median compensation of physician CEOs in healthcare organizations was \$417,934.
3. Median compensation of CFOs in healthcare organizations was \$197,447.
4. Median compensation of chief compliance officers in healthcare organizations was \$104,363.
5. Median compensation of COOs in healthcare organizations was \$210,000.
6. Median compensation of directors of nursing in healthcare organizations was \$82,698.
7. Median compensation of CIOs in healthcare organizations was \$153,087.
8. Median compensation of business office managers in healthcare organizations was \$76,440.
9. Median compensation of medical directors in healthcare organizations was \$258,783.
10. Median compensation of finance directors in healthcare organizations was \$94,745. ■

# 5 Ways Hospitals Will Change Over the Next 10 Years

By Rachel Fields

As the healthcare industry enters a period of major change, hospital administrators must prepare for a number of major challenges — including reimbursement cuts, EMR implementation, stricter compliance measures, new models of care, an influx of insured patients and more — while trying to keep their hospitals financially viable. Here are five ways hospitals are expected to change over the next 10 years — and what hospitals can do to prepare to meet these changes successfully.

**1. Hospitals will redesign their current processes rather than build new facilities.** Andy Day, managing principle of the Hospital of the Future team in GE Healthcare's Performance Solutions business, says over the last eight years, hospitals have been planning to build new clinical facilities to deliver care. As budget cuts take their toll on hospital finances, however, health systems are realizing that a new — and equally financially troubled — hospital may not be the answer. "People are saying, 'Designing a new facility is great, but I don't have access to the capital I used to have, and I have to get more out of the assets I've got,'" Mr. Day says.

Mr. Day says instead of building new facilities, many health systems and third-party companies are reexamining their processes by using simulation modeling to examine how care is delivered. By simulating each step of an average hospital visit, hospitals can determine when the patient is waiting for care and how many providers are used for one patient.

Jim Champy, chairman emeritus of consulting for Dell Services and author of *Reengineering Health Care: A Manifesto for Radically Rethinking Health Care Delivery*, agrees that examining inefficiencies is essential to reducing cost and providing better care. "We found through research that in a four-day stay at a hospital, the patient sees 24 different clinicians and administrators," he says. "That's tremendous complexity. There are 17 steps in a hospital between the time a physician writes a prescription and when the medication gets delivered to the bedside. Healthcare professionals have to really look at the complexity, time and cost of everything they're doing."

**2. Physicians, RNs and physician extenders will do the work that fits their credentialing.** The role of the physician will change as physician extenders are used more and more to fill the roles that physicians are over-credentialed for, says Steve Ronstrom, president of the Western Wisconsin Division of Hospital Sisters Health System. "We need to do some work in getting people through school and certified to work as physician

assistants and nurse practitioners," he says. Instead of assigning physicians to tasks that could be performed by someone with less schooling, hospitals will save money by appointing more physician extenders, which means demand for those positions will likely increase in the next ten years to match the physician shortage.

Mr. Day adds that in a typical hospital, registered nurses are particularly over-qualified for much of the work they do. "In many hospitals, nurses do the RN work plus most of the nursing assistant work and a little bit of the supply tech work," he says. "Since the clinical work was done by the RNs, the nursing assistants start doing support services work, and eventually you're wasting critical clinical resources on work that is below their credentialing." This means making sure RNs are spending the majority of their time on direct patient care and using physician extenders for roles that don't require the credentialing of an RN.

**3. Some hospitals will inevitably fail.** Hospitals across the country are struggling financially, and Mr. Ronstrom predicts those financial obstacles will mean the end of a good number of hospitals over the next 10 years. "In this major time of change we're entering into, there are going to be winners and losers," he says. "I think there will be a number of people who won't be able to meet quality standards no matter how hard they try." He says that while hospitals generally manage to survive a long time, the United States may be entering a period of frequent mergers, acquisitions, turnovers and general dysfunction as hospitals consider multiple methods to stay afloat. "We're going to see winners and losers, and the winners will keep getting better and bigger, and the losers will be forced out," he says.

Mr. Champy agrees that financially strapped hospitals will have to make significant changes to stay viable — and even that may not be enough. "Unless hospitals radically change the way they perform their work to reduce costs and improve quality, we're certainly going to see the financial failure of several hospitals that are right on the edge of profitability," Mr. Champy says. As payments decrease, he says, healthcare delivery organizations are going to have to look at inefficiencies and ineffectiveness and determine where the waste lies.

**4. Hospitals will focus more energy on reducing readmissions.** In 2009, one in five Medicare patients returned to the hospital within 30 days, according to a study published in the *New England Journal of Medicine*. According to experts, readmissions are one of the biggest avoidable costs for hospitals, and CMS currently lists readmission rates as one of the hospital per-

formance measurements on its Hospital Compare website. Going forward, hospitals will be reimbursed less and less for hospital visits that result from an avoidable readmission. Mr. Day says readmission rates must be reduced if hospitals plan to improve patient care, cut costs and comply with healthcare reform measures, and that means communicating effectively with the patient pre-discharge. "A big part of the cause of readmissions is non-compliance with medical directives post-discharge," he says. "Some of that is lack of diligence on the patient's part, but a lot of it is not effectively communicating with the patient and their family. Hospitals should make sure patients can get in touch with a physician after discharge."

Mr. Champy says some readmissions can be reduced with relatively simple patient education techniques. He talks about a hospital that installed a program that prevented adverse medication reactions among elderly patients by having a trained pharmacist call the patient several days after the hospital visit. "They found elderly patients weren't listening. They just wanted to get out of the hospital, and when they got home, they would mix medications and wouldn't know what to do," he says. "Just by calling the patient a few days after and going through everything in the medicine cabinet, they reduced adverse events from around 18 percent to 4 percent in the hospital."

**5. Hospitals will have to focus more on disease prevention.** Most physicians and healthcare experts agree that if hospitals are going to reduce cost of delivery and improve quality, they need to concentrate more time on illness prevention. "We need a massive, massive effort to promote good health," Mr. Champy says. "You don't see the same problems with obesity in other countries. We have a systemic problem with an unhealthy population, and it needs to be solved before we can get those costs down." He says prevention is a matter of educating citizens on a deeper level than before. "It's certainly a matter of education, but it's also a matter of process," he says.

Mr. Champy mentions a program that brought physicians into a city's police department and worked to improve the health of police officers through regular check-ups, classroom visits and one-on-one discussions. By promoting good health in the workplace, hospitals and clinics can ensure workers receive treatment they might otherwise avoid. "In hard economic times, people who are not feeling well don't go to the doctor because they don't have sufficient coverage or they're afraid to take time off work," Mr. Ronstrom says. "One possibility is to put more physicians into the workplace and try to manage the continuum of care there." ■

# The Entrepreneurial Small Practice Is Not Going Away

By **Steve Ronstrom**, CEO of Sacred Heart Hospital, Eau Claire, Wis.

In the race to put together integrated networks, hospitals and large multi-specialty groups are acquiring small medical practices and turning physicians into employees. The solo or small practice, run by a physician with entrepreneurial skills, is said to be dying off. The pundits say physicians will now need economies of scale to survive.

I'm a believer in close alignment of physicians to the hospital to integrate care, but I don't think entering large organizations will be the answer for all physicians. In fact, I think many small practices will not only survive, but thrive. Reports of their demise are greatly exaggerated.

I know of physicians in very small practices who are very busy and highly sought after. If I want to know which physicians people really want to see, I need only go down to the YMCA and ask around. Who's the best knee doctor? Who do you recommend for hearts? Quite often it's the small or solo practitioner, the one who continues to have personal relations with patients.

To me, these entrepreneurial physicians are the super doctors. Even as we go through some tough economic times — and tough times for medicine — my sense is these doctors will keep going strong. They didn't join a large multi-specialty group because they knew they could make it on their own. They have sterling reputations. Their practices will thrive even if they don't align with an accountable care organization. Because of continuing demand for their services, they could probably survive just fine as boutique practices.

## Diverse models of healthcare will continue

The prognosticators want to define one model of healthcare for the future. They look to organizations like Geisinger or Mayo, with their legions of employed physicians working for a fully integrated system. But that's not the only model. In my community, the model is one that includes independent physicians who are not on the hospital payroll or in some large multispecialty group. On my medical staff, there are plenty of physicians in small practices who have no intention of joining a large organization.

Diversity is what made U.S. healthcare great, and I think it will continue to be this way. Because of the way independent medical practices function, these physicians think entrepreneurially. They have very direct relations with revenues and expenses. They are very adaptable to change in the environment in a way that is much more difficult for a large multispecialty group.

In a multispecialty group, physicians lose sight of these exigencies. The physician, now an employee, doesn't walk through the office, keeping an eye on things. It may be true that large groups are better at coding, but I wonder whether the large practice has lost a bit of agility. The secret in managing accounts receivable in a small practice involves knowing every patient as an individual and keeping things as simple as possible. Things can't be that simple in a large group.

## Working with physicians as partners

Small private practices are struggling to meet demands to install electronic medical record sys-



**Ronstrom**

tems. But they will manage. It will be relatively easy for them to piggyback onto a hospital's EMR system and still preserve their independence. Hospitals may want to ask these physicians to join their network, but that may not be in anyone's best interest. When hospital systems employ physicians, accounts receivables escalate and subsidies rise.

Physicians are not just clones. They have to be partners and leaders. One of the members of my board counsels against letting doctors become "country club chefs." These are the chefs who no longer run their own restaurant and now work as an employee of the country club. There is less commitment to the enterprise. If it doesn't work out, you can just move on. But when you are self-employed, you are bound to the community. I believe this applies to self-employed physicians, as well. ■

*Stephen F. Ronstrom has more than 25 years of hospital leadership experience, having served for the past 11 years as an executive in the Hospital Sisters Health System. He is currently president and CEO of the Hospital Sisters' Western Wisconsin division, which includes 344-bed Sacred Heart Hospital in Eau Claire, Wis.*

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# Hospitalists, the Fastest Growing Specialty, Meet Demands of Healthcare Reform

By Leigh Page

**W**ith 30,000 hospitalists in the United States, hospital medicine is the fastest growing medical specialty, and it is expected to play an important role in healthcare reform, according to a report by the *New York Times*.

Under the new law, hospitals will be penalized for readmissions and medical errors, two problems that can be addressed by round-the-clock care by shifts of hospitalists.

While many hospitalist programs were started to contain costs, hospital executives are now more interested in using hospitalists to improve quality and patient coverage, according to a survey of C-Suite level executives at California hospitals, published in the Jan. 2010 issue of the *Journal of Hospital Medicine*.

The survey found that 57 percent expected their hospitalist program to grow during the next two years, and 44 percent of executives without hospitalist programs planned to start one within the next two years.

The percentage of internists practicing as hospitalists rose from 5.9 percent in 1995, when the term “hospitalist” was first used, to 19 percent in 2006, according to a March 2009 study in the *New England Journal of Medicine*.

Now hospitalists are branching out into other specialties. A Feb. 2010 study in the *Archives of Internal Medicine* found that an increasing number of surgery patients are being co-managed by a surgeon and another clinician, such as a hospitalist. From 2001-2006, the last year surveyed,

co-management rates rose more than 11 percent per year. Meanwhile, continued development of obstetric-gynecologic hospitalists was endorsed by a panel from the American College of Obstetricians and Gynecologists in June 2010.

A recent report in the *Statesman Journal* showed how hospitalists are improving care at Sacred Heart Medical Center in RiverBend, Ore. The patient’s personal physician didn’t have time through most of the day to come to the hospital and check on patients. If the patient’s medical condition changed, the physician had to stop seeing appointments and rush to the hospital. And when patients were ready for discharge, they often had to wait hours for their physician to sign the papers. None of this happens with hospitalists, the *Statesman Journal* said. ■

## Study: Hospitalists With Lower Base Salaries Are More Productive

By Rachel Fields

**N**ew data suggests the lower the proportion of total compensation paid as base salary to hospitalists, the higher productivity tends to be, according to the *State of Hospital Medicine: 2010 Report Based on 2009 Data* and an MGMA news release.

Adult hospitalists who received 50 percent or less of their compensation as fixed base salary reported the highest median work relative value units compared to colleagues. Those who received 50 percent or less of their compensation as base salary reported 5,407 wRVUs, compared to 4,591 wRVUs for those who received 51 to 70 percent of their compensation as base salary and 3,859 wRVUs for those who received 71 to 90 percent of their compensation as base salary. Hospitals who received 91 to 100 percent of compensation as base salary had the lowest median reported wRVUs, at 3,571. ■

## Markedly More Surgery Patients Now Co-Managed by Hospitalists

**A**n increasing number of surgery patients are being co-managed by a surgeon and another clinician, such as a hospitalist or internal medicine subspecialist, according to a study in the *Archives of Internal Medicine*.

Co-management by generalist physicians rose by 11.4 percent each year from 2001-2006, and all of that growth was attributed to hospitalists.

Patients more likely to be co-managed were older, with more co-occurring illnesses and in hospitals that were mid-sized, non-teaching or for-profit. ■

# 4 Tips on Implementing a Surgicalist Program at Your Hospital

By Rachel Fields

As patient loads and provider shortages increase, many hospitals are implementing surgicalist programs to accompany the hospitalist programs that came into vogue several years ago. Here, two hospital executives who have been through a surgicalist program implementation with physician staffing company Delphi Healthcare Partners offer four tips on building a surgicalist program that will benefit your patients, physicians and bottom line.

**1. Assess the impact of your current surgeons.** Donald Avery, president and CEO of Fairview Park Hospital in Dublin, Ga., says Fairview Park chose to implement a surgicalist program in part because of a critical need of general surgeons. “We have three general surgeons on staff, all local and board-certified, and two of them are 55 [years of age] or older,” he says. The hospital’s medical staff bylaws say surgeons over 55 can no longer take ER call, meaning that of the hospital’s three surgeons, only one could take call — and he was only doing it for eight or ten nights per month. In addition to the general surgeon shortage, the hospital had two GI physicians on staff, only one of whom was taking GI call. “In those two specialties, we were transferring 20-30 patients a month to other hospitals and not able to receive transfers from other hospitals in those areas,” he says.

In order to implement a successful program, Fairview Park needed to recruit general surgeons dual-qualified in GI. Mr. Avery says because of this unique need, it was essential for the hospital to set high standards and not compromise. “One of the general surgeons we interviewed really didn’t do GI procedures, and we weren’t going to compromise on that,” he says. “We said we just won’t compromise on quality or on the capabilities of the surgeon.”

Ronald May, MD, vice president of medical affairs for New Bern, N.C.-based CarolinaEast Health System, says his system implemented an orthopedic surgicalist program for similar reasons. “We had a number of orthopedic surgeons who decided they couldn’t take call in the ER any longer, and those who continued to take call said, ‘We’re not going to take all the calls,’” he says. “That meant we were going to have gaps in the schedule, which was not okay for the community.” The health system wasn’t enthusiastic about paying for call, so they considered the potential “win-win” situation of implementing surgicalists to take ER call, do inpatient consults and take care of the patient through the outpatient visit. “We thought that might free up the orthopedic surgeons taking call to take other patients and therefore benefit the hospital and community,” he says.

**2. Work with existing physicians to eliminate resistance.** Mr. Avery said the surgicalist program at Fairview Park Hospital initially met some resistance from local physicians who worried the surgicalists would compete with physicians for patient volumes. “Some physicians asked, ‘What if a patient comes to the ER and wants to see their doctor? Will they have to see the surgicalist?’” he says. “We listened to them, and they said they wanted to get the call if a patient asked for it.” Interestingly enough, once the period of resistance passed, most physicians were glad to pass their patients over to the surgicalist — excepting cases when the patient was a close personal friend. The set-up allowed physicians to spend more time in their offices and eliminated the time spend commuting back and forth from the hospital to see patients at the last minute.

Dr. May says the main causes for resistance at CarolinaEast were the concerns about surgicalist qualifications and the possibility of competition. “Some physicians said, ‘Who are these people? Are they qualified to do what they’re going to do?’” He says luckily, the hospital worked to eliminate resistance by involving existing surgeons in the decisions about the program. “The issues were put to rest very quickly, and the surgicalists actually

brought new skills,” he says.

Mr. Avery says one of the most important things a hospital can do to implement a successful surgicalist program is to talk to existing physicians about how the program will work. In the case of Fairview Park Hospital, the surgicalists provided by Delphi were very willing to work with physicians to develop good relationships. Mr. Avery says some surgicalists have even developed great friendships with members of the hospital staff and become an integral part of the community. “They have been accepted very, very well,” he says. “They’ve developed great relationships with the doctors, and they’ve been very willing to combat resistance by talking over misunderstandings of who should deal with a patient.”

**3. Communicate your new surgeon availability to referring providers and hospitals.** According to Mr. Avery, one of the main reasons to implement a surgicalist program at Fairview Park was the hospital’s status as a regional referral center. As the largest hospital between Savannah and Macon, two Georgia cities that sit about 200 miles apart, Fairview Park has services that half a dozen nearby critical access hospitals can’t provide. Because of this, the hospital needed to provide enough surgeons to handle unpredictable regional referrals.

Since the program’s inception, Mr. Avery says Fairview Park has communicated the hospital’s increased surgical services to county EMS ambulance services and regional hospitals. He says the hospital can measure the program’s success in very tangible numbers: since it began, two lives have been saved. “We’ve had two people that, without a surgicalist program, would have died,” he says. “They would not have survived a transfer. That trumps any other thing I can say, and that’s very rewarding to me.” He says the surgicalist program also helps families in the Fairview Park community because surgeries no longer have to be transferred elsewhere when the hospital cannot provide enough surgeons. “It means the family of a patient doesn’t have to drive an hour to see them,” he says.

**4. Consider the eventual financial benefits as well as the up-front cost.** Mr. Avery says that within the next five years, he expects surgicalist programs to become “more the rule than the exception” — possibly even more so than hospitalist programs. He says many hospitals probably don’t consider surgicalists because the up-front cost can be overwhelming. “Typically, you have more admits in the medical arena than you do in the surgical arena, and people figure they don’t need to be that concerned about ER call,” he says.

He says that despite the initial cost of implementing a surgical program, Fairview Park has experienced tremendous financial benefits since the program’s inception. “We transfer fewer patients, which has resulted in jobs and the reopening of our surgery floor,” he says. “We’re doing more surgery cases with a pretty good payor mix, and we’re currently on track to do 400 cases annually.” He says the surgicalist program has increased admissions, revenue and net income, and the hospital anticipates — based on the first quarter — that the program will have a “seven figure positive impact” on earnings.

Dr. May says even if your hospital does not see immediate financial benefits, the hospital will benefit from eliminating gaps in coverage. “The program has generated an increased volume of surgery, and there are no longer patients that need to be taken care of that are stuck waiting for service,” he says. “Because there are two or three doctors here on a regular basis, patients get to learn who they are and develop really good relationships with them.” ■



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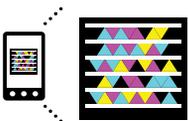
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# Society of Hospital Medicine President Dr. Jeff Wiese Responds to Four Criticisms of Hospital Medicine

By Rachel Fields

**A**s the field of hospital medicine grows and more hospitals implement hospitalist programs, critics wonder whether hospital medicine will hurt quality of care or draw medical students away from primary care. Here Jeff Wiese, MD, president of the Society of Hospital Medicine, responds to four oppositions to hospital medicine.

## **Criticism: The transition from primary care provider to hospitalist hurts patient care.**

**Response:** Dr. Wiese says the biggest opposition to hospitalist medicine has “everything to do with transitions.” He says, “I’ll be first to point out, if you’ve got a perfect primary care provider clinic and a perfect inpatient hospital environment but those two are not communicating back and forth, there’s a risk that the patients will fall through the cracks between the two.” Because the hospitalist model rides on the relationship between PCPs and hospitalist, he says hospitalists have to improve transitions of care.

According to Dr. Wiese, hospitalists and PCPs need to work together to improve transitions into and out of the hospital. Hospitals need to communicate with PCPs to ensure they have information about the patient’s history, preferences, disease management plan and especially medications. If a hospitalist is unaware that a patient is taking a certain medication, he may prescribe a new medication without giving instructions to discontinue the old one.

The other component of successfully transitioning a patient is providing education, Dr. Wiese says. “You need to make sure the PCP and hospitalist are on the same page in respect to the goals of therapy that are appropriate for each individual patient,” he says. If a patient’s PCP and hospitalist never communicate about the patient’s history, preferences and future treatment, then hospitalist medicine will be unsuccessful, but it doesn’t have to be that way. With enough communication, both providers can save time and give the patient the kind of one-on-one attention that a PCP can’t always provide at a moment’s notice.

## **Criticism: Hospitalists make primary care less attractive for future physicians.**

**Response:** Though the healthcare industry is seeing a decrease in residents choosing primary care, hospitalists are not to blame, says Dr. Wiese. In fact, in a functional relationship between hospitalist and PCP, each role compliments the other and cannot function without its counterpart. A study by the University of California on hospital medicine showed two-thirds of primary care physicians supported the hospitalist movement, in-

dicating PCPs believe the presence of hospitalists will give them more time to see patients and less hassle moving back and forth from the office to the hospital.

Dr. Wiese adds that when 32 million Americans gain health insurance for the first time, the relationship between hospitalist and PCP will be essential to freeing up the primary care provider’s time. “It’s a tremendous waste of resources to use a primary care provider for [a hospital visit]. We need to move into proactive mode, not reactive mode,” he says. “More PCPs are going to need even more time in the clinic to handle the increased number of patients, and you lose the luxury to run back and forth between the clinic and the hospital. For those that can develop a trusting relationship with a hospitalist, you can work together to see more patients and provide more care.”

## **Criticism: Hospitalists work for the hospital, not for the patient.**

**Response:** Hospitalists are first and foremost physicians, Dr. Wiese says. “The primary responsibility of a physician is to the patient, and it’s ultimately bad business for the hospital if physicians are doing anything other than providing the best possible care,” he says. The hospitalist may work for the hospital, but the hospital works for the patient, he says. Payment structures for hospitals vary from institution to institution, but the predominant pay arrangement makes hospitalists salaried employees.

## **Criticism: Hospitalists will burn out because of stressful hours.**

**Response:** A well-thought-out job structure can prevent burnout, says Dr. Wiese. He outlines two components to burnout: work intensity and fulfillment. “If they have the right work intensity, not doing overnight every other day throughout the year, they should be fine,” he says. Equally important, he says, is fulfillment. If a hospitalist is embraced by the C-suite and treated as a partner in the overall mission of the hospital, he or she gets to see his or her ideas improve the system.

Dr. Wiese recommends that hospital executives treat hospitalists as “system architects.” This means that a hospitalist is more than just a practitioner who happens to practice in the hospital. Instead, the hospitalist is a provider who’s uniquely familiar with the hospital system, who spends all his time learning the ins and outs of hospital life and who can provide valuable feedback about hospital processes. By involving hospitalists in the strategic goals of the hospital, you can prevent burnout and make them feel like more than a geographically convenient provider. ■



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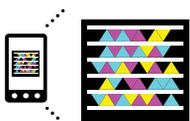
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# 5 Best Practices for Improving Your Hospital's Revenue Cycle

By Jaimie Oh

**W**hen it comes to building efficient revenue cycles, some of the most common challenges facing hospitals today are filing claims to payors without having them denied and collecting bills in a timely manner. Here are five of some of the best practices to tackle these and other issues related to revenue cycles.

**1. Make sure claims are clean and systems are set up optimally.** The first thing Rayanna Moore, system director of revenue cycle for Appalachian Regional Healthcare System in North Carolina, did after discovering accounts receivable were outstanding for 77 days was root out the cause of the problem.

“Only 1 percent of our claims were going cleanly out the door [to payors] without coming back denied, so the first thing we had to do was find where our errors were and why we couldn't get claims out the door,” she says. “We actually took every claim that was produced out of the system, wrote down every error and counted them for two weeks. We found old CPT codes in the system that were not valid and incorrect revenue codes that didn't fit the claim. Settings in the HIS system simply weren't set correctly.”

After fixing the billing system settings, Appalachian was able to reduce the percentage of claims rejected by payors from 99 percent down to 35 percent.

**2. Educate and work with the staff.** Educating the staff on how to properly input information for any department in the revenue cycle – whether it be billing, collections or scheduling – is critical to ensuring accounts are up-to-date and accurate and bills are clean before being sent to insurance companies.

“For the most part the staff wasn't really good at it, and it's because we didn't educate our staff well,” Ms. Moore says. “We worked on front-end collections and started having that department ask patients up front for co-pay and deductibles. We also had to re-educate staff on why it's impor-

tant to get charges on patients' accounts [in a timely manner]. Sometimes charges were forgotten about, so we implemented a new 'point of use' tool that allows staff to use a gun and click on a sticker that will charge automatically to patients' account.”

**3. Form an efficient organizational structure.** Kathy Pope is the regional director of revenue cycle business services for CHRISTUS Schumpert Health System in Shreveport, La., which was one of ten hospitals that won the 2010 MAP Award for High Performance in Revenue Cycle. Ms. Pope attributes much of the hospital's revenue cycle efficiency to the adoption of lean six sigma, a model used in the automotive industry to cut waste and streamline processes.

“We implemented high-performance work teams, which are groups of associates working together in the same area to eliminate waste and re-work errors [in their department],” Ms. Pope says. “Desks are laid out to promote a flow of activities. Departments now also report to the same senior leader.”

**4. Establish processes and use tools that improve revenue cycle efficiency.** Appalachian implemented centralized scheduling and uses QuadraMed's Affinity Revenue Cycle Management solution to help them achieve better efficiency.

“We didn't schedule some appointments effectively, but now that we have centralized scheduling we have a cleaner schedule,” Ms. Moore says. “We're able to see ahead of time how many staff members we need, make sure insurance companies and patients know what they owe, pre-register patients before their appointment so that it's a quick check-in and have them pay for the services up-front. Many things are taken care of ahead of time, and patients are happier because they don't have to wait.”

Kim Hollingsworth, a partner at IMA Consulting, has worked with hospitals in various capacities, including finances and accounting. She also says processes can be streamlined by providing a pre-encounter service. “What pre-encounter service does is take care of the financial issues beforehand so patients come straight in to see a physician without any problems,” she says. “No one should have any surprises with financial responsibility because insurance has been verified and the hospital knows how much the co-pay is.”

**5. Set goals and monitor performance.** Another way to improve revenue cycles is setting periodic measurable goals in place. CHRISTUS Schumpert has a pay-for-performance initiative set in place that establishes goals and rewards for work teams.

“The top-level, overall goal is 'net-to-cash 120 over 120,' and that is what percentage of the net revenue generated 120 days ago is collected within 120 days,” Ms. Pope says. “There are also team goals based on their department, such as time-of-service collections. The work groups, which are based on type of payor, will set a certain percentage of collections as a goal to collect within 120 days. If they achieve the team goal in addition to the top-level goal, they get a team bonus.”

Ms. Hollingsworth also says managing denials goes hand-in-hand with releasing clean claims. “You want to monitor how often your bills are getting denied and what they're getting denied for,” she says. “You want to see denials less than 2 percent of the net revenue. So if a hospital has \$1 million in net revenues, you want to see less than 2 percent of that being denied.” ■

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# 4 Ways to Gain Leverage in Payor Contract Negotiations

By Jaimie Oh

Hospitals are constantly faced with the challenge of negotiating contracts with insurers. The challenge primary lies in finalizing a payor contract that is cost-effective for both the hospital, its patients and the insurer. Here are four best practices for gaining leverage when it comes time to successfully negotiate contracts with third-party payors

**1. Demonstrate achievement in high quality metrics.** As scrutiny on quality of care increases and quality measures become more transparent, it is increasingly important for hospitals to demonstrate not only that they have quality metrics in place but that they are achieving quality standards as well.

“Certain payors are placing more emphasis on quality of care, and if a hospital doesn’t meet a certain standard a payor may not even want a contract with that hospital,” says Janie Patterson, senior vice president at Conifer Health Solutions. “For example, one quality metric a hospital may want to demonstrate is low re-admission rates or mortality rates. Based on quality metrics reported from larger organizations, such as Tenet Healthcare or Hospital Corporation of America, hospitals can compare their quality metrics to others.”

Jordan Battani, principal at CSC Health Services, adds that standardizing quality metrics by incorporating payors’ metrics and requirements set by healthcare reform can give hospitals an added advantage in negotiations.

“Medicare and Medicaid are cutting back reimbursements and creating all kinds of new requirements that are tied to those reimbursements, including high quality of care,” she says. “Health plans themselves are coming under fire from the government to implement these quality requirements, so hospitals should align themselves with the payors.”

**2. Work with payors to achieve operational efficiency on both sides.** Ms. Patterson says a hospital may be able to create better leverage in contract negotiations if it shows it is willing to align itself with the payor to cut down costs on both sides.

“A hospital, for example, might implement electronic transactions so that registrars at hospitals do not have to spend 20 minutes on the phone trying to get an authorization on a claim,” she says. “It’s better for the payor too because it cuts down on time they spend on the phone handling the claim. All organizations are interested in reducing cost.”

**3. Consider alternate reimbursement methods.** As healthcare reform continues to impact reimbursements to healthcare providers, alternate reimbursement methods such as bundled payments are one consideration for hospitals during contract negotiations.

“We’ll see more bundled payments in the coming years when it comes to physician and hospital payments for services,” Ms. Patterson says. “It wouldn’t be open for all service lines, but they can come up with some other creative ideas around alternative reimbursement methods. For example, a hospital could negotiate a special price for cardiac cases that would be all-inclusive for physician and hospital fees based on the hospital’s cardiac case volume. It could give a hospital a more competitive advantage.”

**4. Retrospectively analyze trends in case volume and payor coverage.** Once a hospital comes to the end of a contract, it could look at trends in case volume between services lines and compare that to the business the payors promised to deliver during the contract’s term. In doing so, hospitals can renegotiate terms of coverage and reimbursement rates.

“What a hospital would need to do is look at the type of business that has come from a specific plan,” Ms. Patterson says. “Typically, there are rates based on service provided, such as outpatient services, inpatient services, emergency department services and so on. By looking retrospectively at volumes by service line and comparing that to what a payor indicated would be good business, a hospital can renegotiate for a better contract.” ■

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# 8 Points on Improving Collections of Outstanding Balances From Patients

By Leigh Page

**N**orthShore University HealthSystem, based in Evanston, Ill., launched an initiative seven months ago to improve collections of outstanding balances from patients who come in for more services. Deborah Kirkorsky, vice president of business services at NorthShore, provides some insights on the initiative.

**1. Harder than collecting copays.** NorthShore trained front-office staff 10-12 years ago to collect the copays and raised the copay collection rate to 95 percent. But collecting outstanding balances will be more difficult. The current rate for collecting on outstanding balances is 5-6 percent and the initiative's goal is to raise that rate to 10 percent.

**2. Provide formal training.** From Dec. 2009 to Jan. 2010, NorthShore provided front office staff in-depth training on collecting outstanding balances. Training involved a 40-page training

document with suggested dialog such as, "How would you like to pay that today?" Interactive workshops involved role-playing with participants playing patients and staff.

**3. Cover typical scenarios.** The training document included 10 common scenarios. For example, if the patient says, "I didn't get a bill for that," the staffer can usually provide information on whether the bill was sent. The billing department can even fax a statement to the office for the patient to review. And if the patient says, "This information is not correct," the staff member can offer to put the patient on the phone with the billing office.

**4. Don't push too hard.** Staff are instructed not to persist longer than a few minutes. "We continue if we think we have the potential for collecting it," Ms. Kirkorsky says. "Otherwise, we stop."

**5. Observe legal limits.** The HIPAA privacy law forbids staff from asking about the bill of a spouse or a family member, even though they have the same health insurance policy.

**6. A win-win situation for patients.** Staff members explain that resolving the issue prevents the bill from going to a collections agency. The process also can identify patients who need financial assistance.

**7. Hold contests for staff.** Information on each office's collection rate is posted for employees on the NorthShore intranet site every two weeks. NorthShore holds contests for staff with the best and the most improved collection rates.

**8. Provide help for struggling staff.** Staff who have difficulty asking about outstanding bills get extra help from trainers or successful peers. These mentors can sit with the protégés and help them through the process. ■

## Billing Clinics Improve Collections at Wisconsin's Wheaton Franciscan Healthcare

By Leigh Page

**N**ew billing clinics at Wheaton Franciscan Healthcare Southeast Wisconsin have been extremely popular with patients and ease collections, says Coreen Dicus-Johnson, senior vice president of physician and revenue operations at Wheaton Franciscan.

Every month, patients have an opportunity to meet face-to-face with Wheaton Franciscan billing personnel and review not just the hospital bills but also the payor's explanation of benefits and any other related medical paperwork they don't understand.

"Patients are extremely satisfied with this service and it helps our collection efforts," Ms. Dicus-Johnson says. "Once they understand what is going on, they want to pay the bill, right then and there."

She says billing personnel are just as enthusiastic about staffing the clinics, even though it means stretching the workday an hour or two for the sessions, which run from 2 to 6 p.m. one day a month. "They love the patient contact," Ms. Dicus-Johnson says. "They love using their skills to help someone solve a problem."

### How it works

Wheaton Franciscan advertises its billing clinics

in statements sent to patients. The clinics rotate through three Wheaton Franciscan sites – in Racine, Wauwatosa and Brookfield, Wis. Attendees tend to be Medicare beneficiaries and patients with multiple visits, such as physician therapy sessions. Initially, sessions were scheduled later in the evening, but patients preferred the late-afternoon hours.

Patients are required to call in and make an appointment. "Because it's prescheduled we can do research in advance," Ms. Dicus-Johnson says. "The billing clerk looks for open balances look back six months and gets the lay of the land. This helps facilitate a more meaningful conversation."

Patients arrive at the billing clinic sometimes with great thick stacks of EOBs that are longer than the novel *War and Peace*, according to Ms. Dicus-Johnson. "When you have someone across the table to show your documents to it is highly appreciated," she says.

Several hundred people have come to the clinics since they started in March, but attendance has varied wildly, from 200 to two per session. "We're still learning about scheduling," Ms. Dicus-Johnson says. She says attendance may be influenced

by the cycle for high-deductible payments. Patients seem to be more worried about bills before they reach their deductible later in the year.

Even though billing clinic personnel know how many people will come, they cannot predict how long each session will take, so extra billing personnel are deployed and are given other work to do in case they are not needed.

### The payoffs

Ms. Dicus-Johnson uses the sessions as a sounding board for hospital billing policy. For example, the health system can learn how to make bills more understandable and patients can help monitor outside vendors involved in the billing process. She says the health system recently changed a vendor due to complaints heard at the billing clinic.

"We have collected a lot of money in the clinics, but I'd be hard-pressed to find an ROI," Ms. Dicus-Johnson adds. "We haven't done a cost-benefit analysis." But she believes the billing clinic's biggest value is immeasurable — to improve overall patient loyalty. "We have a relationship with one person going forward," she says. "What is it the MasterCard advertisement says? 'Priceless.'" ■

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# What Makes or Breaks A Successful ACO: Q&A With Dartmouth Brookings Pilot Participant Monarch Healthcare's COO Ray Chicoine

By Lindsey Dunn

**R**ay Chicoine, COO of Monarch Healthcare, a 2,500-physician independent practice organization (IPA) in Orange County, Calif., discusses Monarch's efforts to develop an accountable care organization in Orange County as part of the ACO pilot project spearheaded by the Engelberg Center for Health Care Reform at the Brookings Institution and The Dartmouth Institute for Health Policy and Clinical Practice. Monarch is one of five participants in the pilot program and is currently working closely with HealthCare Partners, a Torrance, Calif.-based physician organization, and Anthem Blue Cross on the project.

## Q: What is the current status of the Monarch pilot?

**Ray Chicoine:** We are in the process of implementing a five-year pilot ACO through the Dartmouth Brookings national pilot slated to become effective Jan. 2011. Monarch was one of the five organizations chosen to participate. We are currently collaborating with Dartmouth/Brookings, HealthCare Partners and Anthem Blue Cross to determine a model that will effectively reduce the cost trajectory of healthcare while improving clinical outcomes. Initially the model will focus on shared savings but all parties agree that for the model to work, a greater degree of financial alignment such as global capitation will be necessary over time.

## Q: Why did Monarch apply to participate in the pilot?

**RC:** We as an organization strongly believe in the promise of accountable care, which is to deliver a higher quality product at a lower cost. The ACO pilot offers us the opportunity to do this for a broader patient population and ultimately will help keep health insurance more affordable for patients in the communities we serve.

## Q: In the Monarch pilot, a physician-owned organization is heading the ACO. However, it is likely many hospitals will develop ACOs in their communities. What is your stance on this?

**RC:** We strongly believe that in markets where physicians have aggregated and have the resources to invest in infrastructure to achieve the necessary level of integration, the ACO model

should be physician-centric but be inclusive of collaborative hospital partners. In areas where a market has a single hospital or hospital system, other more hospital-centric models should be considered. Generally speaking, it is physicians that drive the cost of care by the things they order, where services are performed and how they interact with patients and family members in determining what options are most appropriate in treating a specific illness.

The value system upon which an ACO is based is important, and physician-led organizations have a number of distinct advantages. Physicians possess firsthand experience caring for people over extended periods of time across the entire continuum of care. They are the primary accountable parties when their patients suffer an acute illness and are the primary driver of how effectively longer-term chronic disease is managed. Experiences such as these provide the physician with a unique perspective when trying to balance the difficult choices that are routinely made in providing healthcare.

## Q: In your opinion, what will make or break successful ACOs.?

**RC:** First, you need the engagement and support of the provider community. The ACO concept is unknown among many independent practicing physicians, so an effective communication plan and ongoing education is critical.

A second key element is effectively aligning financial incentives. Figuring out how to align incentives among the employer/payor, physicians, hospitals and other ancillary providers will pose significant challenges. We have a theoretical understanding that all stakeholders in the ACO will share in the expected savings, but ensuring that these savings are allocated equitably will be critical. Successful ACOs will need to reduce unnecessary utilization, which means there will be less overall dollars spent, and that waste has to come from somewhere. If a hospital within the ACO has less volume, they would want shared savings to help offset these volume losses. Employers may feel that the majority of the savings should go back to them in the form of reduced premiums. The physicians who are doing the majority of the work to produce these savings will look for that work to be valued appropriately.



Chicoine

Finding the right balance will require a greater degree of transparency and collaboration among the various stakeholders than currently exists in most relationships. ACOs currently are largely a theoretical concept that must be transitioned to an effective organizational or contractual model that works in a transforming market.

In conclusion, I believe the ultimate success of an ACO will be based upon the vision and values that it embodies. Some ACOs being created today will succeed while others will fail if they are not truly committed to the ACO principles. How an ACO fares will be determined by why its participants form it. There will be organizations who envision an ACO as their next high-margin revenue model or as a new way to increase negotiating leverage. These ACOs will not be capable of fulfilling the ACO promise and thus will fail. On the other hand, providers and executives who understand to whom and for what they are accountable will design high-quality cost-efficient models for the communities they have committed to serve. ■

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# 10 Statistics Your Hospital Should Track

By Rachel Fields

**Y**ou can't manage what you don't measure: that seems to be the mantra of every hospital executive, as electronic data systems increasingly help hospitals track data on quality measures, patient satisfaction and revenue. Here five hospital leaders discuss ten statistics every hospital should track.

## Daily

**1. Quality measures, such as infection rates, patient falls and overall mortality.** CMS requires hospitals measure a variety of quality statistics, including hospital-acquired infection rates, associated diseases and readmissions. Kathy Young, CEO of St. Joseph Hospital in Kokomo, Ind., says hospital administrators should keep their eye on those core measures and identify several that the hospital needs to improve upon or watch for. "We watch our patient fall rates to make sure we improve our performance if our rates get too high," she says. Looking at statistics on quality measures might not be possible more than once a month because the data is not available, but Ms. Young says hospitals should still talk over patient safety issues every day.

In order to keep patient safety issues front and center, her hospital holds a "daily huddle" where staff members discuss upcoming or potential safety issues as well as mistakes that have happened in the past 24 hours. This "daily huddle" means that patient safety problems are not forgotten over the course of a week or a month, and hospital administrators and department heads have a good idea of the hospital's strengths and weaknesses. If you hold a regular meeting to discuss patient safety issues, you won't be surprised when you look at monthly data and find your hospital is underperforming in certain areas.

**2. Patient census statistics.** As well as calculating revenue and collections, your hospital should track patient census statistics to determine when you experience the biggest patient load and when that load drops off, says John Fontanetta, MD, chairman of the emergency department at Clara Maass Medical Center in Belleville, N.J. His experience in the emergency department has taught him that patient satisfaction drops off steeply when the number of patients outmatches the number of available beds. By tracking your patient census and reviewing it on a daily basis, you can determine which departments are overburdened, which times of year are the busiest and which departments are seeing a declining stream of patients.

Ms. Young says she watches inpatient census and surgery volume every day, but she also regularly watches for changes in the number of cases for an individual physician. "If I see any changes in that number, I want to pick that up right away and follow up," she says. "If you don't get in contact immediately, somebody might be mad at you for months and you wouldn't know about it."

**3. Discharged not final billed claims.** If your hospital has a claim that's been discharged and clear-coded but it hasn't arrived at the payor yet, there is something wrong with the claim that means it's not clearing the edits. If you aren't tracking DNFB claims, you won't be able to research why your hospital never received payment and how your billing department is submitting flawed claims. The status of DNFB claims should be reviewed every day to ensure billers and collectors know the status of the hospital's payments. Hospitals can also make sure they have a linkage to the payor, so that when the payor receives the file, they notify the hospital of the claim's status. Over-time statistics on DNFB claims can be reviewed less regularly — for example, every month — to get a "big picture" look at how many claims are being processed incorrectly.

Your hospital should also track claims that are hung up with the payor,

says Steve Mooney, president of revenue cycle solutions at Conifer Health Solutions. "Once the bill has left the hospital, a lot of hospitals stop paying attention to it," he says. "I think we're going to see a lot more focus on those neglected claims."

## Monthly

**1. Point-of-service cash collections.** Point-of-service collections are defined as the collection of the portion of the bill that is the responsibility of the patient prior to the provision of service, which could mean payment is received before the procedure or on the day of the procedure. In order to note where your hospital is losing money, you need to know how much you collect from the patient on a monthly basis and how much of that is collected on point of service. Data on point-of-service cash collections should be reviewed monthly so your hospital can regularly examine and adjust its collections policy if necessary.

"There's a big initiative to contact a patient as soon as they are scheduled to find out if they are insured, who their insurance company is and whether their procedure is covered by insurance," says Mr. Mooney. "You want to determine the co-pay and deductible and call the patient beforehand to ask if they'd like to pay in advance or at the hospital." By calling the patient several days before the procedure, you set up an expectation that they will pay the claim when they arrive at the hospital, Mr. Mooney says.

**2. Percentage of charity care.** Tracking your hospital's percentage of charity care differs depending on non-profit or for-profit status. Non-profit hospitals have to provide a certain amount of charity care, and in order to qualify for funding, they must identify charity care cases and track the data. "It's very important for tax status to capture that population," Mr. Mooney says. "You want to triage the financial ability of a patient to pay as soon as possible. We have a tool that looks at every patient who comes through the doors of the hospital and looks at their credit report and looks at census bureau data and tries to figure out their propensity to pay."

If your hospital is for-profit, you should track your percentage of charity care and review it monthly to determine how you can route uninsured, non-emergency patients to other facilities. If your emergency department is frequently used to treat non-life-threatening situations, your hospital might talk to uninsured patients about using local clinics. For uninsured patients who are using the emergency room for real emergencies, your hospital can talk to patients about how to qualify for Medicaid. "A lot of patients who don't have insurance today use emergency rooms," Mr. Mooney says. "If it's an emergency, you can use a financial counselor once the patient is through the ER to talk about Medicaid, how to get food stamps in their community and how to improve their lifestyle in general."

**3. Percentage of budget spent for each department.** Every department should schedule a regular review of its budget and spending to figure out where your hospital is spending the most money, says Faye Deich, chief operating officer at Sacred Heart Hospital in Eau Claire, Wis. "During a cost-saving initiative, we put together diverse groups of people to look at various department budgets. This helped to train department leaders and others within the organization to think about cost management," she says. "Our goal was to find out if we could use different supplies at a lower cost, or if we should be negotiating harder with vendor contracts." She says by reviewing the budgets on a departmental level, the hospital found it was renting wheelchairs when it had the resources to buy them.

She recommends asking each department team to achieve a specific target based on their team's sum portion of total hospital expenses. It's a lot harder to see where you're potentially wasting money from the macro level.

If you get down to the nitty-gritty details of each department, you may find — like Ms. Deich did — that you can save several thousand dollars a year just by switching your brand of garbage bags.

**4. Door-to-discharge times.** Dr. Fontanetta says tracking door-to-discharge times — the amount of time a hospital visit takes from the moment the patient walks in the door to the moment they are discharged — is essential to determine where your bottlenecks exist. Especially in the emergency department, he says, hand-offs happen so quickly that providers may not be aware of the time a patient spent sitting around the waiting room. He says an EMR is extremely helpful in tracking a statistic like door-to-discharge times because it allows your staff members to look at data on a rolling basis. “You can only imagine how hard it would be to track those times manually,” he says. “You would need four to five FTEs on the project, and you wouldn’t be as accurate as an EMR.”

With a quality EMR, Dr. Fontanetta says you should be able to break up your door-to-discharge times into different sections to determine where bottlenecks occur. You should look at door-to-triage time, triage-to-room time, room-to-doctor time, doctor-to-order time and order-to-discharge time within the overall time the patient spends in the hospital. “If you find out your times are high, you can drill down on that and find exactly where the problem is,” he says.

Dr. Fontanetta says once you have information on your door-to-discharge times, you should compare your hospital to other similar hospitals. You won’t know how your wait times and procedure times measure up if you don’t compare the data to other hospitals on a quarterly basis.

**5. Patient satisfaction scores.** If you want to gauge efficiency, com-

fort and quality in your hospital, ask your patients. Ms. Deich says her hospital looks at patient satisfaction rates on a weekly and monthly basis to get a sense of why patients are dissatisfied and how they can improve. “We know it’s not statistically significant to look at scores on a weekly basis, and we don’t go jumping off in a certain direction based on one weekly score, but it gives you an idea of how things are looking,” she says. “We’re shooting for the top decile as our target, so we’re trying to set a pretty high bar.”

She says administrators review patient satisfaction scores from a third-party company on a weekly basis to identify immediate issues and then review again on a monthly basis to make decisions about policy changes.

Dave Veillette, president and CEO of Cancer Treatment Centers of America at Western Regional Medicine Center in Goodyear, Ariz., recommends asking customers to rate how likely they are to recommend a particular hospital service. Your hospital can effectively gauge patient satisfaction by asking, “Would you recommend this service to a family member?” Ms. Deich and Mr. Veillette both also recommend soliciting patient feedback through daily rounds and sharing that information at regular department meetings. Not all patient satisfaction indicators will be statistics, they say. By soliciting and sharing anecdotal evidence about patient experience, your hospital can get feedback on problems that may not fit on a “0-9 satisfaction level” survey.

## Annually

**1. Colleague satisfaction scores.** Your hospital should do an annual colleague satisfaction survey that asks each staff member for input on the hospital’s policies and practices, strategic direction, staff communication and other topics. Once you have the results of that survey, share them with your colleagues and form tangible solutions for several common complaints. Ms. Deich says she gives a presentation to the staff on the feedback the hospital received and the hospital’s priorities following the colleague satisfaction survey each year.

In order to keep up with colleague complaints and concerns, Ms. Deich says her hospital also issues a “pulse survey” with 10 or 12 questions every quarter. “We want to get a sense of how our colleagues feel about working here and the respect level between staff members,” she says.

**2. Market share and service line development.** As well as regularly monitoring statistics on revenue, your hospital should look at market share and service line development on a monthly basis to determine how you should increase your market share or develop or expand more profitable service lines. Comparing your revenue from each service line with the costs associated with that line can tell you which lines are profitable and should be expanded, and which lines are no longer profitable and might be discontinued. This research can be combined with research in your community to determine which lines best fit the health needs of the surrounding area. If your hospital is in an area with several competing hospitals and clinics, review your market share quarterly to determine where you are losing customers and how you can increase your attractiveness to potential patients.

Your hospital should look at information on community demographics and illness rates on a quarterly — or, if the information is not available that regularly, yearly — basis to evaluate whether you are offering the right services. For example, a community where many residents suffer from heart disease should have a robust cardiology service line. ■



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## HHS Starts Talks on 2013 Measures for Second Stage of Meaningful Use

By Jaimie Oh

Although healthcare providers are just starting to take on the challenge of meeting the 2011 first stage requirements of the meaningful use incentive program, the Department of Health & Human Services has already started talks over second stage measures of the incentive program, according to a *Government Health IT* report.

The Health IT Policy Committee is aiming to have recommendations for the 2013 second stage meaningful use criteria by April, which is a challenge considering not much will be known about the experiences of healthcare providers meeting stage one requirements. The committee hopes the April deadline will give vendors of healthcare information technology enough time to build upon their electronic health record systems.

A meaningful use work group will be holding informational hearings and issuing requests for comments later this year to hear healthcare providers' feedback about the direction and timetable for the 2013 second stage meaningful use criteria. Another quality work group will discuss more robust clinical quality measures for the second stage measures. ■

## HIMSS Launches State HIT Dashboard, Alerts Healthcare Providers of Health IT-Related News

By Jaimie Oh

HIMSS has launched a State HIT Dashboard ([www.himss.org/statedashboard](http://www.himss.org/statedashboard)), which is designed to help healthcare providers access credible and comprehensive information about relevant health IT programs and initiatives across the country, according to an HIMSS news release.

The State HIT Dashboard tracks the following initiatives:

- **State resources:** a single repository of state-specific information, state organizations and state-related resources.
- **Regional extension centers:** Name and amount awarded information about the RECs.
- **Health information exchanges:** Name, location and details of self-reporting HIEs, including state-designated entities.
- **State legislation tracking:** Description and reference information on pending state legislation as it pertains to healthcare IT.
- **Davies Award recipients:** Name, location, organizational description and affiliated news releases of Davies Award recipients.
- **HIMSS chapter information:** Links and locations of HIMSS chapters.

The State HIT Dashboard also updates information as it becomes available. ■

## National Health IT Coordinator David Blumenthal Hints More Complex Requirements for 2013 Stage 2 Meaningful Use

By Jaimie Oh

National Health IT Coordinator David Blumenthal, MD, is signaling to healthcare providers and vendors that requirements for the 2013 stage two of meaningful use will be more complex and robust, according to a *Government Health IT* news report.

Dr. Blumenthal made his comments at an event that acknowledged the top 10 states where physicians were employing e-prescribing. "We know there were a set of unfinished tasks, things we passed over in the effort to get the first stage of meaningful use out the door," he said at the event. He has also suggested stage two will incorporate greater clinical decision support, which lacked in stage one. ■

## New Government Health IT Panel to Set Road Rules for Nationwide Health Information Network

By Jaimie Oh

A new government health IT advisory panel is working toward establishing road rules for the nationwide health information network, according to a *Government Health IT* report.

The federal panel was formed to create a process — not standards or policies — that will ensure healthcare providers exchange patient health information securely over the information network. No such road rules exist yet for the NHIN. The panel aims to identify potential areas of governance, including security, data integrity, identity management and symmetry of participation. It will also assess what would be governed by a single entity and when the Office of the National Coordinator would be involved in governance activities.

The advisory panel is planning to host information panels on Sept. 28 to hear from other industries, such as the banking industry, about their own established rules on exchanging trusted information. The panel will make its recommendations to the Health IT Policy Committee in October. ■

# GOP's New 'Pledge to America' Puts \$19B in HIT Stimulus Funds at Risk

By Leigh Page

House Republicans' newly released legislative agenda, "A Pledge to America," includes a call to cancel any unspent money from the economic stimulus program, according to a report by the *New York Times*.

Unspent stimulus funding would include \$19 billion in healthcare IT incentives that HHS plans to dole out to hospitals and physicians offices that upgrade their IT systems to meet federal "meaningful use" criteria.

House GOP leaders did not specifically address HIT funding, but their pledge included plans to roll back non-discretionary spending to 2008 levels before the TARP and stimulus bills were passed, saving \$100 billion in the first year alone.

As part of stimulus funding, each hospital could receive as much as \$11 million and physicians' offices could receive as much as \$44,000 to \$64,000 per physician. The 21-page plan also calls for the repeal of the healthcare reform law, presuming a GOP takeover of Congress in the November elections. In any case, President Obama would be expected to veto GOP actions against both the healthcare reform and stimulus acts.

"A Pledge to America" is divided into five policy areas: the economy, government spending, healthcare, government reform and national security. "Across America, the people see a government in Washington that isn't listening, doesn't get it and doesn't care," said House Minority Leader John Boehner (R-Ohio). ■

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# 4 Steps to Creating a Great Hospital Marketing Campaign

By Rachel Fields

**A**s increasing patient volume becomes tantamount to staying financially viable, hospitals must think about how they market their services to potential referring physicians and patients. Dan Weinbach, executive vice president with The Weinbach Group, discusses four steps hospitals should follow to create an attractive marketing campaign for a set of service lines.

**1. Conduct market research.** Before you start deciding how to market your hospital, you need to know what your competitors are doing and who your audience is. For example, if your hospital is located just down the road from Cleveland Clinic, arguably the hospital providing the best heart care in the country, it might be difficult to market your hospital as a cardiology leader. When your board looks at patient volume for a particular service line and feels dissatisfied, they need to benchmark that data against national and local hospital data to determine how effective a marketing campaign will be. “You may discover you have 95 percent of the market in our particular service line, so your expectations for growth need to be mitigated against what you can get out of the market,” Mr. Weinbach says.

Market research should also look at the needs of your community. What are the greatest care demands in your community, and how does your hospital plan to meet them? If your community has a high incidence of heart disease or diabetes, you might start a campaign to market your cardiology line or diabetic care program. If your patients are primarily frustrated by their inability to get an appointment, you might market your hospital’s “same day appointment” policy. Mr. Weinbach says hospitals often get too caught up in advertising the assets that the hospital values rather than those the customer values. “Your hospital might be proud of a specific clinical technology, but sometimes those aren’t the things that matter most to patients,” he says.

Your research should also examine how your hospital is currently perceived. “Once you have information on how [the market perceives you], you can start setting goals for messages and decide whether the campaign will repair [negative] conceptions or amplify [positive ones],” he says. If the public views your hospital negatively, you need to either make changes in your hospital or plan a marketing campaign to correct misconceptions.

**2. Prioritize marketing goals.** Once you have conducted market research, you need to take a systematic approach to marketing as opposed to a reactive approach. “You shouldn’t engage in a campaign to promote cardiology services because the chair of the department has asked for a campaign,” Mr. Weinbach says. “Marketing service lines should be [based on] empirical studies.” Instead of allowing every physician and administrator with an agenda to prioritize for you, base your decisions on tangible factors such as:

- How much capacity does a particular service line have?
- What does the service line contribute to the hospital’s bottom line?
- What is the market potential for growth in the service line?
- What technological resources can the service line offer patients?

In deciding which service lines to market, Mr. Weinbach says hospitals should look to the advice of David Ogilvy, the father of advertising: “Milk

your winners and kill your losers.” That doesn’t mean eliminating service lines, necessarily, but you should focus on service lines that are generating demand and increasing volume. If you have service lines that haven’t received as much attention but have great market potential, those lines are also candidates for a marketing campaign. The lines that you shouldn’t focus on are those with little room for market share growth, little contribution to the hospital’s bottom line and few relationships with referring physicians. Focus on those lines that can really make a difference to your revenue and physician relationships.

**3. Figure out your budget.** Once you’ve decided which service lines you will use for your campaign, you need to plan your budget. This may mean tweaking your service line decision somewhat depending on finances. “You may discover you don’t have the budget to market five different service lines,” Mr. Weinbach says. “The budget and your priorities are very reliant on each other.” When you set the budget, you need to make sure you provide room to market for three audiences: referring physicians, internal audiences and consumers. Prioritize the budget for each audience based on how much volume each campaign might drive. “If you think about it, one healthy physician referrer can translate into literally hundreds of patients,” Mr. Weinbach says. “You may determine you can get more mileage out of your budget by focusing on service lines that have a strong physician referral component.”

Several decades ago, Mr. Weinbach says marketing budgets were determined based on a percentage of total revenue that was relatively similar from hospital to hospital. Now “the budgets literally cross the gamut,” he says. In the recent trying economic times, he says many hospitals have made cuts to their marketing budgets as a way to save money — a move Mr. Weinbach says is a mistake. “Marketing is not any more disposable than human resources, accounting and finance and food services,” he says. “Even if marketing doesn’t have a direct correlation to patient care, a hospital without patients can’t provide good patient care.”

**4. Create a tactical plan.** Once you have a strategic plan in place detailing the service lines you will target, you need to create a tactical plan to figure out the “nuts and bolts” of your campaign. “That tactical plan will be repeatable steps, like print ads, direct mail pieces, TV campaigns and radio campaigns that are influenced by your strategy,” Mr. Weinbach says.

This means going back to your budget and deciding how you will target each audience. “The internal marketing team or an outside healthcare marketing firm can determine the best approach for each audience,” he says. “You might want to send direct mail, do TV campaigns, do radio campaigns or put up billboards, but it all depends [on how your audiences receive the majority of their information].”

He says the tactical plan is essential for when physicians and other staff members approach you with requests for additional campaign material. “In hospital environments, we’re constantly being barraged with requests from departments, physicians and administrators for specific support for programs and doctors and technologies,” he says. “If you don’t have a plan to wave in someone’s face, the more likely they are to yell louder about their needs and the more likely you are to say yes.” ■

# 3 Ways Hospitals Unintentionally Waste Money

By Rachel Fields

Even as hospitals across the country increase their focus on reducing costs through job cuts and other efforts, they may be losing money in unexpected places. Here Andy Day, managing principle of the Hospital of the Future team in GE Healthcare's Performance Solutions business, shares three ways your hospital may be wasting resources — and how to reverse that cash flow to benefit your facility.

## 1. Medical staff members perform duties below their credentials.

In many hospitals, medical staff members are working hard but not necessarily performing the tasks in their job description, says Mr. Day. "If you go into a typical hospital, you'll see people working hard on primary delivery of care, but they're not necessarily doing the things that are most important or aligned with their capabilities," he says. "You'll see RNs running all over the place, doing their work as well as some of the nursing assistants' work and some of the supply techs' work." He says when RNs perform clinical duties assigned to nursing assistants, the nursing assistants fill their time by working on support services tasks, thus creating a "flow-down effect" in which over-qualified staff members are performing duties assigned to other people. Because those staff members are more highly compensated, you end up paying clinical staff to do work that doesn't require medical training.

"You don't want RNs doing things that could be done by anybody," says Mr. Day. "You want to focus them on more patient education and

symptomatology. In my experience, RNs spend only a third of their time in front of patients, and more than half of that time isn't spend on the right stuff." When you restructure your hospital to ensure RNs are spending time on clinical care, you end up with a lower FTE cost per case but a higher level of quality, Mr. Day says. You will also be able to redeploy nurses to areas suffering from nurse shortages because your RNs won't be busy with tasks that aren't their responsibility.

## 2. Hospitals are unaware of the real rate of supply and device utilization.

Mr. Day says many hospitals think their devices and supplies are more highly utilized than they really are. "When you measure it, some devices are used half as much as you think," he says. "We regularly see people thinking their pumps are 70 percent utilized when they're actually only 30 percent utilized." He says hospitals may be ordering more pumps because the medical staff thinks they've run out, when in fact, the pumps are hidden in closets and supply rooms. If your hospital is renting and buying supplies and devices that aren't being used, you will suffer financially because of a simple misunderstanding.

This resource waste can be tackled with ID tags and supply tracking, Mr. Day says. "If you have an ID tag on that pump, for example, and you know where it's going and how it's being used, you can start being very strategic about how it's being used and get much better utilization out of it," he says. "That's a good example of how

technology can result in productivity and efficiency."

## 3. Inadequate patient communication causes more readmissions.

Improving patient education and communication will be even more essential as hospitals prepare to handle the influx of newly insured Americans in 2011. If hospitals are going to handle an increased patient load with a decreased number of physicians, hospital administrators and medical staff need to work together to reduce readmissions and improve patient health overall. "A big part of the cause of readmissions is non-compliance with medical directives post discharge," Mr. Day says. "Some of that is lack of diligence by the patient, but a lot of it not effectively communicating with the patient and their family. Hospitals need to make sure the patient is in touch with a physician resource after discharge so they can avoid unnecessary readmissions that hospitals are going to be less and less reimbursed for."

Mr. Day believes hospitals should pay more attention to managing patients outside the acute-care setting. This can be done by promoting relationships with primary care physicians, increasing patient and family education before discharge and using EMR technology to communicate with patients outside the hospital on a regular basis. As reimbursements for readmissions get lower and lower, hospitals must find a way to create a healthier, more informed patient population or face financial penalties for providing sub-par care the first time around. ■

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# Developing a Culture of Execution: A Precursor to Success Under Health Reform

By Lindsey Dunn

**H**ealthcare organizations have to become increasingly effective and efficient not only to thrive, but just to survive, under healthcare reform. In return for an additional 32 million insured Americans, hospitals agreed a \$155 billion cut in reimbursements over 10 years, which means hospitals will have to become even more effective just to maintain current performance.

"In terms of pure dollars, a hospital with a 5 percent operating margin today will start sliding into the red by about 2014-2015 if its volume and productivity stay the same," says Quint Studer, founder of the Studer Group.

## Tactics vs. culture

According to Mr. Studer, too many hospitals see these bleak projections and immediately jump to the conclusion that new tactics must be put in place. Process improvement efforts, best practice programs and more complex efforts to accept bundled payments with physicians are just a few examples of some of these tactics. However, Mr. Studer says that hospitals must first establish an organizational culture that promotes execution. "Hospitals already have knowledge of tactics to improve effectiveness and efficiency. They know how to prevent falls and reduce readmissions, but efforts fail upon execution," he says.

What will separate the winners from the losers in their ability to become maximally effective organizations and prosper in light of reform is a culture that requires continual improvement, he says.

## Three elements of a "culture of execution"

**Alignment.** According to Mr. Studer, a culture of execution requires alignment, consistency and accountability. Successful alignment means that all levels of hospital staff share the same goals and understanding of the healthcare marketplace. Mr. Studer says many hospital CEOs see the external environment differently than frontline supervisors because leadership is constantly looking to the future while frontline supervisors are more often focused on the immediate needs of their departments. "There is less of a sense of urgency the farther down you go in the organizational chart," he says. It is understandable due to the role each plays.

A recent survey by Studer Group asked C-suite executives and frontline supervisors at several health systems the following question: "If leaders in your organization continue to perform exactly as they do today, will your results over the next five years be much worse, somewhat worse, better, the same or much better?" The survey found that the majority of senior leaders felt that their organization would be much worse if nothing changed, while 63 percent of frontline supervisors thought that the organization would be perform about the same or better.

In order to help all employees understand the need for improved efficiency, hospital leaders should use every opportunity available to them to share this message with employees. Mr. Studer recommends holding quarterly employee meetings and spending some time addressing this issue at each meeting as well as providing information about changes on the horizon in every employee newsletter.

**Consistency.** Hospitals also need to have consistent leadership that promotes the implementation of best practices across the organization. All leaders need to support efforts to improve the organization because inconsistent

support by leaders will undermine efforts. "One of the biggest parts of healthcare reform is taking best practices and putting them into place. It's not that we don't know how to prevent hospital acquired-pneumonia, falls or infection, it's that we can't execute it," says Mr. Studer.

What do hospitals need to do then to execute successfully? Mr. Studer says it goes back to alignment. "Even if hospital leaders consistently support an effort, getting employee buy-in for these changes often means you have to connect to the why," he says. "Make them understand the need for the change."

**Accountability.** Finally, a culture of execution requires all staff to be accountable in meeting performance goals. Accountability means holding leaders and employees responsible for job performance. Research by the Studer Group suggests that healthcare organizations often overstate the employee's level of performance, part of which may be due to outdated performance evaluation tools. "We're trying to build world-class healthcare using a pre-historic evaluation tool," says Mr. Studer. "If I can underperform and still get a good evaluation, then the hospital is reinforcing underperformance."

Evaluation tools should be based on objective, measurable goals. For example, a hospital CEO might be evaluated against the hospital's ability to meet a desired patient satisfaction rating. Mr. Studer also recommends that they allow certain areas to be weighted higher than others, as to better emphasize core hospital or department goals.

After an organization gets an appropriate evaluation tool in place, it has to follow through on dealing with subpar performers. "If leaders and employees aren't performing to expectations, you're never going to make the kind of improvements required by reform," says Mr. Studer. ■

*Quint Studer is a recognized leader and change agent in the healthcare industry and has more than 25 years of healthcare experience.*



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## 25 Largest Hospitals

Here are the 25 largest hospitals in the United States listed by number of beds. These facilities include for-profit and non-profit hospitals, with some hospitals being part of a larger health system. *Note: The hospital bed counts reported here include all medical/surgical and special care beds as reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include bed counts from other facilities that share a provider number with the main hospital.*

1. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City), Beds: 2,236.
2. Florida Hospital Orlando (Orlando, Fla.), Beds: 2,001.
3. Jackson Memorial Hospital (Miami), Beds: 1,756.
4. University of Pittsburgh Medical Center Presbyterian (Pittsburgh), Beds: 1,602.
5. Methodist Hospital (Indianapolis), Beds: 1,450.
6. Montefiore Medical Center – Moses Division Hospital (New York City), Beds: 1,427.
7. Methodist Hospital (San Antonio), Beds: 1,414.
8. Baptist Medical Center (San Antonio), Beds: 1,402.
9. Orlando Regional Medical Center (Orlando, Fla.), Beds: 1,376.
10. Methodist University Hospital (Memphis, Tenn.), Beds: 1,273.
11. The Cleveland Clinic (Cleveland), Beds: 1,270.
12. Barnes-Jewish Hospital (St. Louis, Mo.), Beds: 1,258.
13. Buffalo General Hospital (Buffalo, N.Y.), Beds: 1,241.
14. The Mount Sinai Medical Center (New York City) Beds: 1,223.
15. Norton Hospital (Louisville, Ky.), Beds: 1,150.
16. Erie County Medical Center (Buffalo, N.Y.), Beds: 1,137.
17. Memorial Hermann Southwest Hospital (Houston), Beds: 1,136.
18. UAB Hospital (Birmingham, Ala.), Beds: 1,121.
19. North Shore University Hospital (Manhasset, N.Y.), Beds: 1,082.
20. Christiana Hospital (Newark, Del.), Beds: 1,081.
21. Beaumont Hospital, Royal Oak (Royal Oak, Mich.), Beds: 1,061.
22. Spectrum Health Butterworth Hospital (Grand Rapids, Mich.), Beds: 1,033.
23. Coler-Goldwater Specialty Hospital & Nursing Facility – Coler Campus (Roosevelt Island, N.Y.), Beds: 1,025.
24. Jewish Hospital (Louisville, Ky.), Beds: 1,025.
25. Albert Einstein Medical Center (Philadelphia), Beds: 1,018. ■

## 25 Top Grossing Hospitals

Here are the 50 top grossing short term acute-care hospitals in the United States listed by gross revenue, according to CMS cost report data analyzed by American Hospital Directory. *Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.*

1. University of Pittsburgh Medical Center Presbyterian (Pittsburgh), Revenue: \$9.8 billion.
2. The Cleveland Clinic (Cleveland), Revenue: \$9.1 billion.
3. Cedars-Sinai Medical Center (Los Angeles), Revenue: \$7.2 billion.
4. Florida Hospital Orlando (Orlando, Fla.), Revenue: \$7.1 billion.
5. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City), Revenue: \$6.8 billion.
6. Stanford Hospital (Stanford, Calif.), Revenue: \$6.0 billion.
7. University of California San Francisco Medical Center at Parnassus (San Francisco), Revenue: \$5.6 billion.
8. Temple University Hospital (Philadelphia), Revenue: \$5.5 billion.
9. Hospital of the University of Pennsylvania (Philadelphia), Revenue: \$5.4 billion.
10. Montefiore Medical Center – Moses Division Hospital (New York City), Revenue: \$5.4 billion.
11. Orlando Regional Medical Center (Orlando), Revenue: \$5.3 billion.
12. Massachusetts General Hospital (Boston), Revenue: \$5.1 billion.
13. University of California Davis Medical Center (Sacramento, Calif.), Revenue: \$4.8 billion.
14. Hackensack University Medical Center (Hackensack, N.J.), Revenue: \$4.7 billion.
15. Crozer-Chester Medical Center (Upland, Pa.), Revenue: \$4.6 billion.
16. Ohio State University Hospital (Columbus, Ohio), Revenue: \$4.4 billion.
17. Brigham and Women's Hospital (Boston), Revenue: \$4.3 billion.
18. Jackson Memorial Hospital (Miami), Revenue: \$4.2 billion.
19. The Methodist Hospital (Houston), Revenue: \$4.0 billion.
20. Thomas Jefferson University Hospital (Philadelphia), Revenue: \$4.0 billion.
21. Vanderbilt University Medical Center (Nashville, Tenn.), Revenue: \$4.0 billion.
22. Methodist Hospital (San Antonio, Texas), Revenue: \$3.9 billion.
23. Northwestern Memorial Hospital (Chicago), Revenue: \$3.8 billion.
24. Tampa General Hospital (Tampa, Fla.), Revenue: \$3.8 billion.
25. University of Texas M. D. Anderson Cancer Center (Houston), Revenue: \$3.7 billion. ■

# Hospital & Health System Executives Moves

Florida-based Jackson Health System named **Mark Knight** CFO.

**Kenneth Cochran**, CEO of Cibola General Hospital in Grants, N.M., announced that he will resign effective Nov. 1.

Memorial Hermann Healthcare System announced the promotion of **Craig Cordola** to CEO of Memorial Hermann-Texas Medical Center in Houston.

Tenet Healthcare Corporation named **Eric Evans** as CEO of Lake Pointe Health Network in Rowlett, Texas.

Saint Thomas Health Services named **Dawn Rudolph** CEO of Saint Thomas Hospital in Nashville, Tenn.

**Gary Kaatz**, president and CEO of Rockford Health System, was elected chair of the Illinois Hospital Association's 2011 board of trustees.

**Gladys George**, the longtime president and CEO of Lenox Hill Hospital in New York City, announced she will retire at the end of the year after 20 years leading the hospital.

Nantucket (Mass.) Cottage Hospital named **Margot Hartmann**, MD, president and CEO.

**Kevin Haughney**, CEO of Inter-Lakes Health in Ticonderoga, N.Y., stepped down.

The McKenna System in New Braunfels, Texas, announced that CEO **Tim Brierty** will resign from the leadership position in October.

Summa Health System in Akron, Ohio, named **Tom DeBord** as president of Summa Barberton (Ohio) and Summa Wadsworth-Rittman (Ohio) hospitals.

Sharon (Conn.) Hospital named **Kimberly A. Lumia**, the hospital's chief nursing officer, as president and CEO.

Harvard Pilgrim Health Care in Wellesley, Mass., named **Roberta Herman**, MD, as COO.

Mercy Hospital Anderson in Cincinnati named **Gyasi Chisley** as its new COO.

The board of hospital trustees of the city of Needles, Calif., approved hiring **Mark Uffer**, former county administrative officer, as the new CEO of Colorado River Medical Center in Needles.

**Molly Sandvig**, executive director of Physician Hospitals of America, said she will leave her position to become COO of Joint Replacement Hospitals of America, a new for-profit company developing knee- and hip-replacement hospitals to be run by physicians.

**Kevin B. Churchwell**, MD, was named CEO of Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del.

**Mitch Katz**, the current director of San Francisco's public health department, said he plans to leave the city at the beginning of 2011 to become health director for Los Angeles County.

University of Cincinnati Health named **W. Brian Gibler**, MD, as president and CEO of University Hospital in Cincinnati, as well as senior vice president of UC Health.

Tenet Healthcare Corporation appointed **Carolyn Jackson** as CEO of St. Christopher's Hospital for Children in Philadelphia.

Lahey Clinic in Burlington, Mass., chose **Howard R. Grant**, MD, as the hospital's next president and CEO.

Indiana's Clarian Health named **Philip M. Dulberger**, MD, as CEO and CMO for Clarian Saxony Medical Center, currently under construction in Fishers, Ind.

Hospital Corporation of America named **Greg Caples** COO of Summit Medical Center in Hermitage, Tenn.

Silverton (Ore.) Hospital named **Rick Cagen** as its new vice president and administrator.

**Alvin R. Lawson**, JD, CEO of Pleasant Valley Hospital in Point Pleasant, W. Va., announced he will leave the hospital to accept a job with HealthSouth Western Regional Rehabilitation Hospital in Parkersburg, W. Va.

Lakeland (Fla.) Regional Medical Center named **Elaine Thompson** president.

**Larry Dodds**, executive vice president and COO of Adventist Health, headquartered in Roseville, Calif., announced he will retire in May after almost 40 years with the health system.

Beaufort Regional Health Systems in Washington, N.C., named **Richard A. Reif** interim CFO.

Providence Tarzana (Calif.) Medical Center named **Phyllis Bushart** as the hospital's new COO and CNO.

West Chester (Ohio) Hospital named **Kevin Joseph**, MD, as its new CEO, making permanent the role of interim CEO he has filled since May. ■

# Hospital & Health System Transactions

Winter Park, Fla.-based **Adventist Health System** has officially merged with the Tampa, Fla.-based network **University Community Health** to form the Tampa Bay region of the healthcare network.

Franklin, Tenn.-based **Community Health Systems** expects to finalize its purchase of the assets of Youngstown, Ohio-based **Forum Health**.

**Community Health Systems**, based in Franklin, Tenn., will be up against three other health systems in its bid to operate **Beaufort** (N.C.) **Regional Health System**.

The Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice have cleared **Vanguard Health System's** \$1.5 billion acquisition of **Detroit Medical Center**, granting early termination of a 30-day pre-merger waiting period.

**Fisherman's Hospital** in Marathon, Fla., has finalized the transition from its previous 25-year lease with Health Management Associates to a new agreement with **Quorum Health Resources**.

**Grubb & Ellis Healthcare REIT II** announced its acquisition of **Joplin** (Mo.) **Long-Term Acute Care Hospital**.

Milwaukee, Wis.-based **Froedtert Health** has completed its purchase of six medical practices in Menomonee Falls, Germantown and Hartford, Wis., from **ProHealth Care Medical Associates** based in Waukesha County.

Dallas-based investment firm **Highlander Partners** and healthcare and financial services industry-focused private equity firm **Flexpoint Ford** have completed the acquisition of Atlanta-based **Eagle Hospital Physicians**.

Franklin, Tenn.-based **IASIS Healthcare** announced an agreement to purchase **Brim Holdings** of Brentwood, Tenn., for \$95 million.

St. Joseph, Mich.-based **Lakeland HealthCare** plans to buy **Community Hospital** in Watervliet, Mich. later this year.

**Lawrence (Mass.) General Hospital** has announced an affiliation with **Beth Israel Deaconess Medical Center** in Boston.

**LifePoint Hospitals** has finalized its acquisition of Gallatin, Tenn.-based **Sumner Regional Health Systems** for the cash price of \$156.8 million.

Traverse City, Mich.-based **Munson Healthcare** is expected to release details on its planned affiliation with **Spectrum Health**, based in Grand Rapids, Mich.

The city of **New Orleans** has officially acquired **Methodist Hospital** from Universal Health Services for \$16.25 million.

**Newton (N.J.) Memorial Hospital** and Morristown, N.J.-based **Atlantic Health Systems** are expected to vote on a possible merger.

The board of commissioners of the **North Broward Hospital District** has voted to authorize Broward Health President and CEO Frank Nask to coordinate the transition of the Fort Lauderdale, Fla.-based health-care system to a new community not-for-profit corporation.

**Pike County Memorial Hospital** in Murfreesboro, Ark., has been acquired by Louisville, Ky.-based **New Directions Health Systems** for \$2 million.

Wall, N.J.-based **Meridian Health** has completed its merger with **Bayshore Community Hospital and Health Services** in Holmdel, N.J.

Temple, Texas-based **Scott & White Healthcare** has finalized its agreement to merge with **Johns Community Hospital** in Taylor, Texas.

**Select Medical Holdings**, based in Mechanicsburg, Pa., has completed its acquisition of Alpharetta, Ga.-based **Regency Hospital Company**.

Central Texas-based **Seton Family of Hospitals** has acquired **Smithville (Texas) Regional Hospital**.

The **Southeast Volusia Hospital District Board** has reapproved the decision to move forward with an affiliation for its **Bert Fish Medical Center** in New Smyrna Beach, Fla.

Grand Rapids, Mich.-based **Metro Health**, Novi, Mich.-based **Trinity Health** and **University of Michigan Health System**, based in Ann Arbor, have joined together to launch **Pennant Health Alliance**.

**University of Michigan Health Systems**, based in Ann Arbor, Mich., has approached Traverse City-based **Munson Healthcare** about an expanded relationship amid a decision by Munson on a possible affiliation with Grand Rapids, Mich.-based **Spectrum Health**.

Fairmont, W.Va.-based **West Virginia United Health System** has announced it will acquire **St. Joseph's Hospital** in Parkersburg, W.Va. ■

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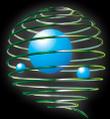
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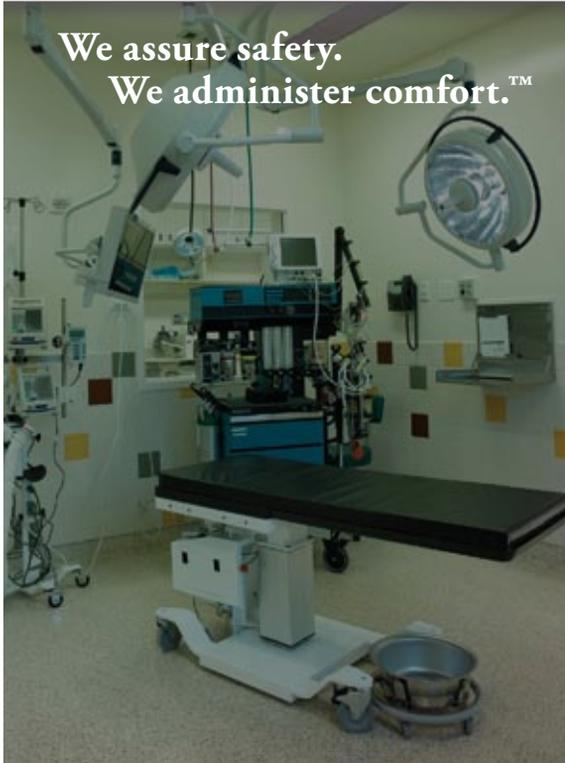
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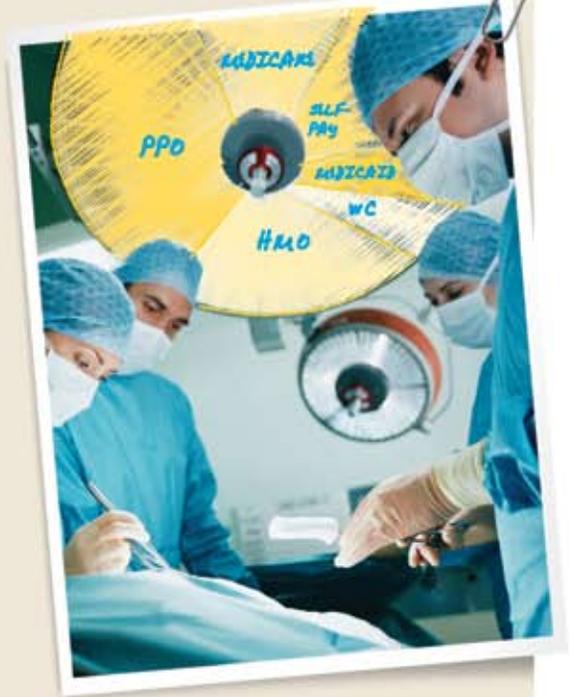


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