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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

November/December 2011 • Vol. 2011 No. 9

10 "Biggest" Hospital Stories of 2011

2011 has not been a quiet year for healthcare. During the last 12 months, a number of provisions within the healthcare reform law went into effect, and proposed rules and guidance for several innovative programs created by the law were released, all while the nation's courts heard cases arguing against the law's constitutionality. How healthcare reform plays out in the coming year will certainly influence the future of the nation's healthcare delivery system, and while health systems must strategically plan ahead, many remain greatly concerned with the present. Reimbursement pressures from public and private payors alike have created ongoing efforts to cut costs, and this year, a number of

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From Treating the Sick to Managing Community Health: Hospitals' New Role in Managing Population Health

By Lindsey Dunn

Hospitals have long provided services aimed at improving the health of their communities, usually as part of their community benefit programs. It's hard to find a hospital that doesn't offer educational sessions, free screenings and other preventive health services, and many hospitals go beyond that. For example, hospitals are increasingly using nurse

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From Cop to CEO: Q&A With Chris Van Gorder of Scripps Health

By Molly Gamble

Chris Van Gorder was named CEO of the five-hospital Scripps Health, based in San Diego, in 2000. Under his tenure, the health system has experienced a \$150 million financial turnaround and plans to invest more than \$3 billion in inpatient and outpatient expansion projects across the region over the next 20 years. A former police officer, Mr. Van Gorder's approach to management improved physician relations and boosted employee satisfaction, leaving Scripps as one of *Fortune's* "100 Best Companies to Work For" for the past four years.

Mr. Van Gorder discusses his role as a teacher, the importance of prompt decision-making, and why the title "hospital CEO" may become extinct in the years to come.

Q: You were critically injured after responding to a family dispute call as a police officer

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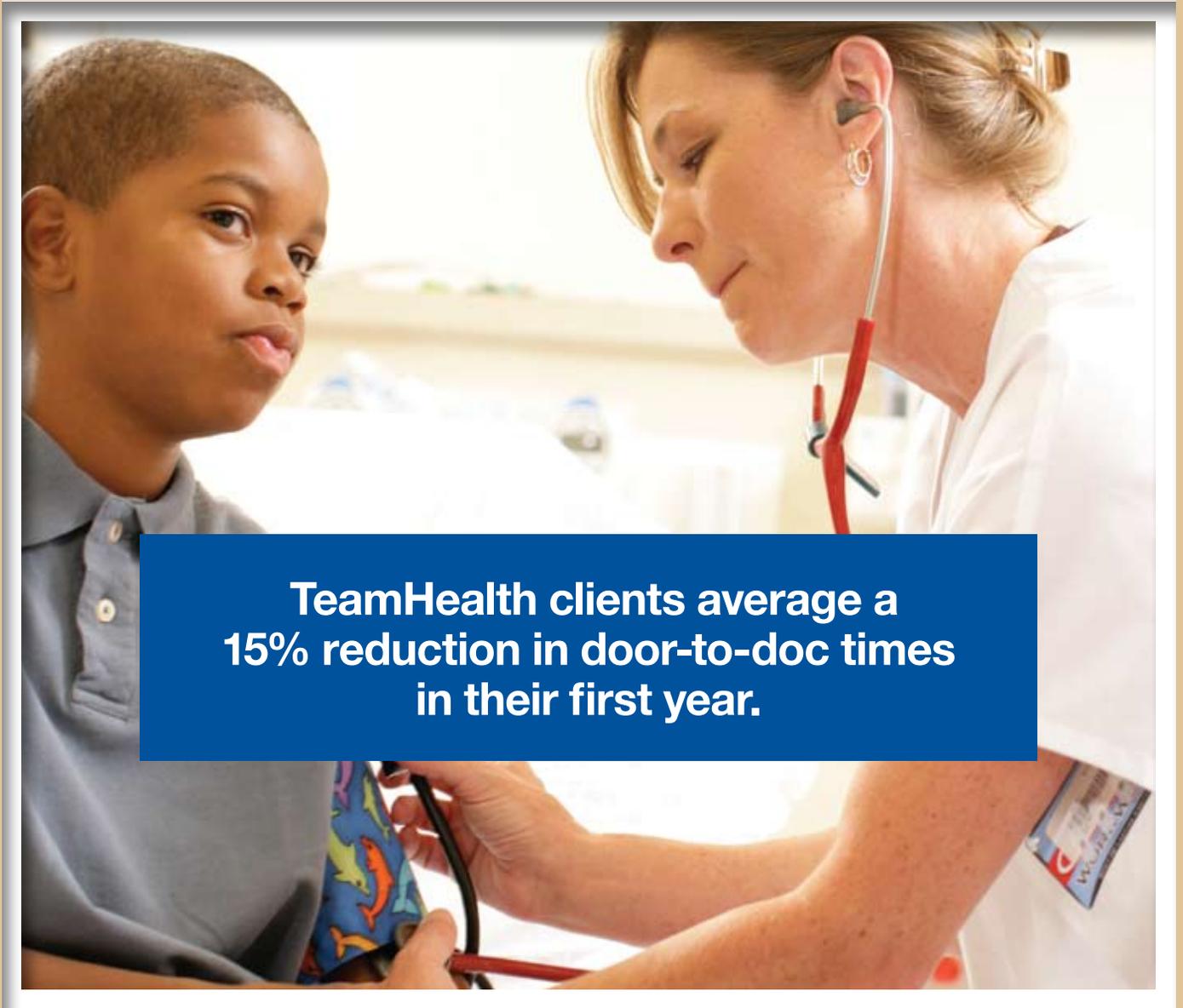
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Publisher's Letter

Becker's Hospital Review Benchmarking Issue; 2012 Becker's Hospital Review Annual Meeting

November/December Issue. We are pleased to share with you the November/December Issue of *Becker's Hospital Review*, our annual benchmarking issue, which contains 200 quality, financial and operational hospital benchmarks. The special benchmarking section begins on page 16.

This issue also includes an overview of the "biggest" healthcare stories of 2011. From the release of the Medicare Shared Savings Program proposed rule and the frenzy around the pros and cons of accountable care organizations that followed to the release of the more-positively received Bundled Payments for Care Improvement initiative, 2011 has been an exciting year. In regards to Bundled Payments for Care Improvement, Valinda Rutledge, director of the Patient Care Models Group at CMS' Center for Medicare and Medicaid Innovation, discusses the initiative's rationale and answers some frequently asked questions on the new guidelines on page 27.

At the time of this letter's writing, healthcare continues to be at the forefront of the national political stage. Medicare and Medicaid cuts to reduce the national deficit are currently up in the air, but the need to continue to reform these programs isn't likely to fade away, even after the supercommittee makes its recommendations. Healthcare issues are being widely debated by presidential candidates, and the healthcare reform law will soon reach the nation's highest court — all suggesting 2012 will be no less of an eventful year for those in the industry.

Becker's Hospital Review Annual Meeting. Please save the date for the Becker's Hospital Review Annual Meeting — CEO Strategy, ACOs, Physician-Hospital Integration, Improving Profits and Key Specialties. The event will take place from May 17-18, 2012 at the Hotel Allegro in Chicago. Chuck Lauer, former publisher of *Modern Healthcare* and now a career coach and motivational speaker, and myself will

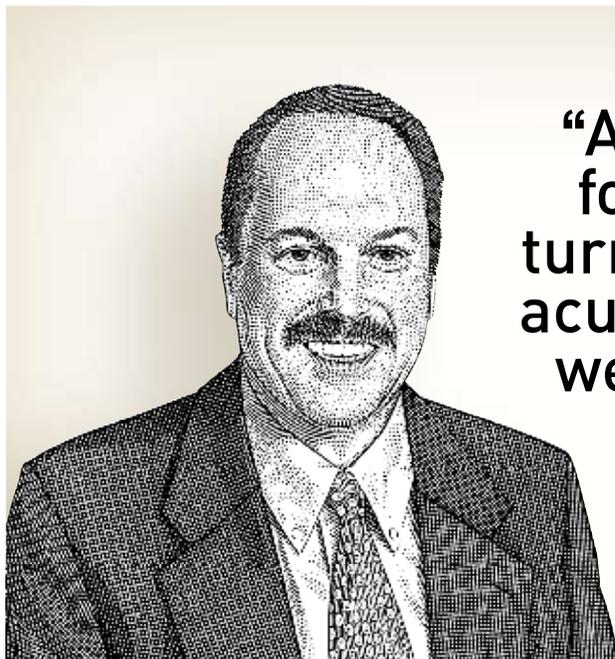
serve as co-chairs for the event. We are pleased to welcome keynote speakers Bob Woodward, Mike Ditka and Suzy Welch as well as a line-up of outstanding industry speakers, including a number of well-recognized hospital and health system CEOs, CFOs and other C-suite executives. For more information on the event, visit www.BeckersHospitalReview.com.

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

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Scott Becker, Publisher, *Becker's Hospital Review*



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10 "Biggest" Hospital Stories of 2011 (continued from page 1)

hospitals found they could not longer do it alone, selling their facilities to larger operators or merging with regional providers. While 2011 has been a tumultuous year, it's also been an exciting one. Here is a look back at the biggest hospital-industry stories of the year.

1. Challenges to Patient Protection and Affordable Care Act heard in federal courts. Challenges to President Barack Obama's healthcare reform law, formally known as the Patient Protection and Affordable Care Act, have been heard in federal courts across the country this year, with three cases proceeding to federal appeals courts as of this article's writing. The effort is being led by Florida in a 26-state lawsuit that argues the healthcare reform law and its provisions, particularly the individual insurance mandate, are unconstitutional. Although one appeals court has ruled the insurance mandate is unconstitutional, President Obama expressed confidence that his hallmark legislation will stand in the Supreme Court. Because of the mixed rulings among the appeals courts, it is expected challenges to the reform law will make it all the way to high court, possibly by the end of the year.

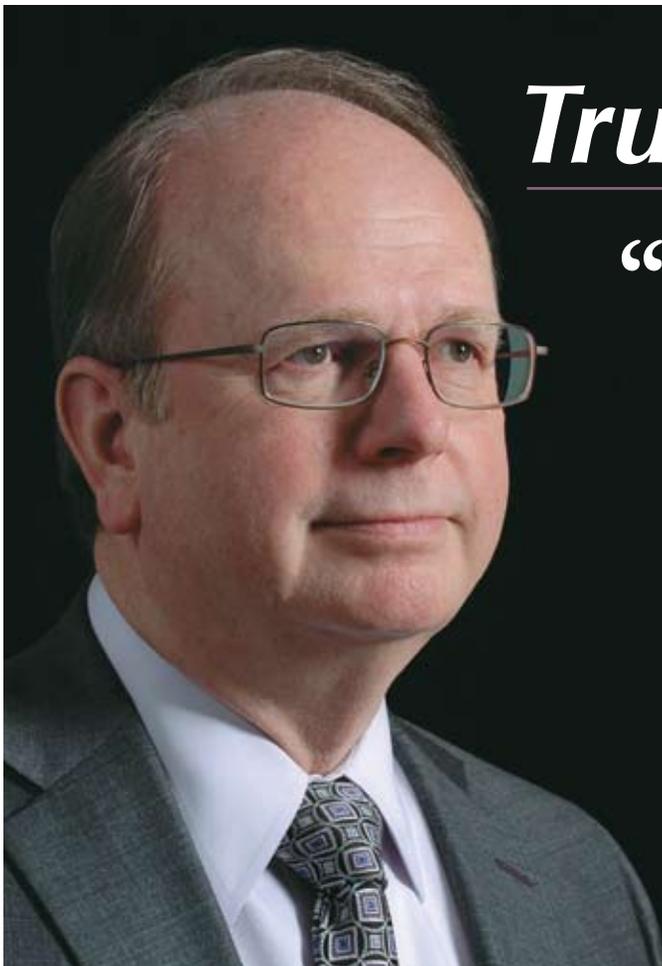
In June, a three-judge panel in a Cincinnati federal court ruled 2 to 1 to uphold the PPACA, becoming the first appellate court to rule in favor of the constitutionality of the individual mandate. Then, a federal appeals court in Atlanta ruled in August that the insurance mandate provision of the healthcare reform law is unconstitutional. While the three-judge panel voted 2-1 that Congress cannot require all Americans to buy health insurance, the court ruled the rest of the healthcare law is constitutional. In early September, a federal appeals court in Virginia was the third federal court to hear a challenge to the healthcare reform law, this time filed by Virginia

Attorney General Ken Cuccinelli. The appeals court ruled Mr. Cuccinelli cannot legally challenge the individual mandate because the provision does not impose any obligations on the state itself.

Soon after the Virginia court ruling, a judge in a Pennsylvania federal district court ruled the individual mandate unconstitutional and struck it, and two other provisions, from the healthcare reform law. Although not an appeals court ruling, this ruling marks the first time a judge has ruled other provisions, aside from the insurance mandate, unconstitutional. The other two mandates require insurance companies to cover everyone who wants to buy a policy and prohibit discriminating those with preexisting conditions. The judge argued that the three provisions work together and deemed them inseparable by law.

2. Debt ceiling deals leave Medicare, Medicaid funding in limbo. The country's deficit reduction problem has been highly contentious this year, with political heads dueling over how exactly to close the country's staggering \$14.3 trillion debt. Although Congress has approved an increase to the country's debt ceiling, the new debt reduction law has made healthcare programs, including Medicare and Medicaid, vulnerable to required cuts. Lawmakers, principally from the right, have suggested putting Medicare and Medicaid on the chopping block, spurring a firestorm of criticism and opposition from Democrats and the healthcare industry.

Just before the country's Aug. 2 default deadline, Congress approved the Budget Control Act, under which the country's debt ceiling would be raised by \$2.1 trillion to \$2.4 trillion in two stages. As part of the deal, a new special Congressional "supercommittee" would be formed to find at least \$1.2 trillion in dollar-for-dollar savings to match the debt ceiling increase. If the committee fails to recommend the savings by the end of this year, as much as



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\$1.2 trillion in automatic cuts would be enacted, including a 2 percent cut in Medicare payments to hospitals, physicians and other Medicare providers.

In September, President Obama submitted a proposal for deficit reduction to the deficit reduction committee, which includes \$320 billion in savings across both Medicare and Medicaid programs. President Obama's proposal would reduce the nation's debt by approximately \$3 trillion over the next 10 years. His plan features savings of \$248 billion through Medicare, partly by reducing bad debt payment to 25 percent for all eligible providers over three years starting in 2013 and payment reductions to critical access hospitals. Medicaid savings include lower Medicaid disproportionate share allotments for hospitals. Worth noting, however, is that President Obama's plan assumes the Medicare sustainable growth rate will remain intact, which is unlikely. If Congress acts before the end of the year to do away with the scheduled payment cuts under the SGR, additional savings may need to be identified.

3. Accountable care organization proposed regulations released. CMS released the proposed regulations for its Medicare Shared Savings Program, better known as the health reform-mandated program that creates Medicare ACOs, on March 31. The regulations were highly anticipated and were quickly dissected by healthcare providers, many of whom had a number of looming questions about how ACOs would function under the regulations. Designed to reduce healthcare costs by coordinating care, the program would allow ACOs that keep healthcare costs for an assigned beneficiary population below expected spending targets to share in the savings created (above the minimum savings rate, generally 2 percent). ACOs would need to have infrastructure in place to distribute the savings to participating entities, suggesting that less technologically advanced organizations may not be ready to participate in the program's initial Jan. 1, 2012 launch.

Under the proposed rule, ACOs can choose from two risk models. Under the first, "one-sided," risk model, an ACO that creates a savings of at least 2 percent would get 50 percent of the money above that threshold, but it would have no penalty if it spent more in the first and second year. Under the "two-sided" model, an ACO could receive 60 percent of the money above the threshold but also would be penalized if it led to higher costs. By the third year of the program, all ACOs would become responsible for losses. ACOs would be required to meet certain quality thresholds, and the regulations impose several governance and reporting requirements on the organizations.

After the regulations were released, many providers voiced concerns over the administrative burdens required of ACO participation. Cleveland Clinic President and CEO Delos "Toby" Cosgrove told CMS through a letter that the Clinic was "disappointed" with the proposed rule, saying it contained too many prescriptive and reporting requirements not directly related to outcomes. The letter also warned that retrospective assignment of beneficiaries to ACOs — which means beneficiaries are assigned after the performance period based on utilization data during that period — could make it difficult for providers to impact quality and costs. Donald W. Fisher, PhD, president of the American Medical Group Association, captured the concerns of many providers when he wrote in a letter to CMS, "It's really hard to drive up quality and lower costs for patients when you don't know who they are." Intermountain Healthcare, Mayo Clinic and Geisinger Health System, all large integrated delivery networks poised for ACO participation, also said they were unlikely to participate, causing many to question the future of a program which was once thought to be a game changer in bending the healthcare cost curve.

In May, CMS released regulations for two more ACO models intended for more advanced organizations: the Pioneer ACO and the Advanced Payment ACO. The Pioneer ACO model was "designed to work in coordi-

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nation with private payors,” according to CMS, while the Advance Payment ACO model “would provide additional upfront funding to providers to support the formation of new ACOs.” Only a few providers, such as the 13-hospital Mountain States Health Alliance and IntegraNet, a Houston-based physician network, had applied for the program by early fall. It appears the big detractors have yet to sway.

While the future of the Medicare ACO program remains uncertain, it appears providers are not opposed to the inherent goals of an ACO. In fact, throughout the year a number of big providers announced ACO-like arrangements with private payors. Health systems also took much more kindly to CMS' Bundled Payments for Care Improvement initiative, also created by the PPACA. CMS released a request for application on Aug. 22, and many found the program's design to be fairly unambiguous while providing flexibility to providers. The initiative allows providers to participate in one or more of four models, which include both retrospective and prospective payment as well as both acute-care only, post-acute only and combined designs. It will be interesting to see if providers' interest in the program results in filed applications, which aren't due for models 2-4 until next year.

4. Evolving relationships between payors and providers. Two related but distinct trends emerged in 2011: insurers buying physician groups and insurers buying hospitals. In the past year, four of the five largest health insurers increased physician holdings, according to news reports.

In September, UnitedHealth Group struck a deal to acquire 2,300 physicians through its purchase of Monarch Healthcare — the largest medical group in California's Orange County. Earlier in June, Indianapolis-based WellPoint acquired CareMore Health Group, a health plan operator based in Cerritos, Calif., that owns 26 clinics. With primary care physicians already in high demand, insurers could potentially wrest control of entire health systems in certain markets by influencing referrals.

A proposed deal between Pittsburgh-based insurer Highmark and West Penn Allegheny Health also stirred feathers in the industry. Under the proposed transaction, Highmark would buy the system for nearly \$500 million and assume approximately \$1 billion in liabilities. West Penn's rival, University of Pittsburgh Medical Center, has since refused contracting with Highmark after learning of the acquisition to avoid subsidizing competition. UPMC and Highmark were already in the midst of a contract dispute, but news of the payor's takeover of West Penn finally made UPMC want a “divorce” from Highmark, as UPMC CEO Jeffrey Romoff put it. Unlike payors and physicians, there has yet to be a formal transaction between a payor and a major hospital system, making this proposed deal one to keep an eye on throughout 2012.

Relationships between payors and providers took some other interesting turns in 2011, though short of mergers and acquisitions. Some payors publicly called out hospitals for providing what they deemed “high-cost care.” In January, Blue Cross Blue Shield of Massachusetts launched its Blue Cross Hospital Choice plan, which limits the use of 15 higher-cost hospitals. Under the plan, BCBS beneficiaries face extra charges if they go to “high-cost” hospitals like Brigham and Women's Hospital, Massachusetts General Hospital and Dana Farber Cancer Institute.

Rather than being at the receiving end of the blame-game, other providers have taken a proactive approach in their relationships with payors. In September, Boston-based Steward Health Care partnered with Tufts Health Plan to launch an insurance plan. It will require consumers to use Steward-affiliated physicians and facilities for routine needs but is expected to cost 15 to 30 percent less than comparable commercial plans.

5. For-profit organizations ramp up acquisitions. For-profit, investor-owned organizations accounted for some of the biggest healthcare transactions in 2011. The deals followed two noteworthy deals at the end of 2010 that paved the way for significant for-profit M&A activity. Vanguard Health Systems bought eight-hospital Detroit Medical Center for \$1.4 billion in Dec. 2010 while Cerberus Capital Management-backed Steward Health Care System scooped up Boston-based Caritas Christi Health Care for \$895 million in Nov. 2010.

In Jan. 2011, Brentwood, Tenn.-based LifePoint Hospitals announced the formation of a unique joint venture with Durham, N.C.-based Duke University Health System. Also during the year, Steward purchased several more hospitals within Massachusetts, announced plans to go national and developed plans to work with non-profit Tufts Health Plan to create Steward Community Choice, a new insurance plan that requires consumers to use it for routine healthcare needs with Steward-affiliated physicians and facilities. Prime Healthcare Services began negotiations to buy failing Christ Hospital in Jersey City, N.J. And, Community Health Systems, based in Franklin, Tenn., announced its intent to acquire Scranton, Pa.-based Moses Taylor Health Care System, part of a large-scale hospital grab in Pennsylvania against non-profit Danville, Pa.-based Geisinger Health System.

6. Tenet repeatedly rejects CHS' takeover bids. Dallas-based Tenet Healthcare's rejection of a takeover bid from Franklin, Tenn.-based Community Health Systems and the ensuing lawsuits related to the deal gained a lot of attention from the hospital industry and investors during 2011. The nearly nine-month power struggle began in Nov. 2010 when CHS offered an unsolicited \$3.3 billion bid for Tenet. CHS also said it would assume Tenet's roughly \$4 billion in debt, but Tenet rejected the offer as

inadequate. In the following months, Tenet also rejected CHS' all-cash offer of \$6 per share and its “best and final offer” of \$7.25 per share, saying the bids were too low.

To defend against CHS' takeover attempts, Tenet adopted a “poison pill” device that specified if any person or firm bought more than 4.9 percent of Tenet's shares without its board's approval, all other shareholders who own less than that percentage of shares could buy additional shares at a bargain price. Tenet also removed annual meeting timing requirements from its bylaws, which allowed the company to delay its board meeting for 2011, during which all of Tenet's 10 board members would be up for reelection. CHS had selected its own slate of 10 nominees for the Tenet board positions as it prepared to acquire the company. Following the failed deal, Tenet sued CHS for damages related to the costs of resisting the takeover bid.

Meanwhile, both Tenet and CHS faced lawsuits by shareholders, and Tenet sued CHS. Tenet was sued twice by shareholders for allegedly breaching its fiduciary obligations, first by rejecting CHS' original \$7.3 million offer and later by changing the company's bylaws to prevent the CHS takeover. In April, Tenet accused CHS of systematically overbilling Medicare and unnecessarily converting emergency department visits, or observation stays, into inpatient admissions, a lawsuit that CHS called baseless. CHS shareholders filed suit against the hospital operator seeking to recoup stock losses, as CHS shares dropped 36 percent following the lawsuit. In June, CHS shareholders filed suit against the hospital operator again, alleging securities fraud and schemes by the company to artificially inflate stock prices. All cases are still pending.

Tenet's shares also declined following its lawsuit against CHS, dropping 15 percent to \$6.44 per share. In September, Tenet closed at \$4.46 per share.

7. Non-profit hospitals established as active acquirers. While the merger and acquisition market has been most noticeably active for many for-profit healthcare entities, non-profit hospitals kept pace, providing several noteworthy partnerships and deals. Provena Health in Mokena, Ill., signed a deal to merge with Chicago-based Resurrection Health Care, and Novi, Mich.-based Trinity Health has been active in merging hospitals in western Michigan. However, none has been more highly publicized than the potential merger between University Hospital in Louisville, Louisville-based Jewish Hospital and St. Mary's Healthcare and Lexington, Ky.-based St. Joseph Health System. Jewish Hospital and St. Joseph are both part of Denver-based Catholic Health Initiatives. The deal initially presented potential complications to the boundary between church and state by pairing an academic institution with a Catholic system. Recently, University of Louisville officials said there's been too much attention focused on possible problems with the merger rather than its

benefits. While the deal has not been finalized, it has sparked discussion over the importance of non-profit hospitals' creativity in healthcare transactions.

As hospitals and physicians gear up for collaborative models outlined in the PPACA, non-profit health systems have also been involved in acquiring physician practices. Some of the significant transactions include the University of Pittsburgh Medical Center's purchase of Erie (Pa.) Physicians Network; The Christ Hospital acquiring several surgical practices; St. Louis-based SSM Health Care acquiring oncology and orthopedic practices; and New Bern, N.C.-based CarolinaEast Health System acquiring East Carolina Internal Medicine based in Pollocksville, N.C., which employed more than 350 physicians and staff.

8. Physician employment continues to rise.

This year, physicians increasingly sought employment by hospitals, and hospitals increased efforts to employ physicians. In fact, Irving Levin Associates reported a 200 percent increase in physician group mergers and acquisitions in the second quarter 2011 compared to the same period the year before. Furthermore, physician group M&A activity increased 50 percent from Q1 2011 to Q2 2011. An article, "Hospitals' Race to Employ Physicians — The Logic Behind a Money-Losing Proposition," published in *The New England Journal of Medicine* in May, reported that more than half of practicing U.S. physicians were employed by hospitals or integrated delivery systems. A study by Accenture in June estimated only 33 percent of physicians will remain independent by 2013.

This growing trend has significant implications for physician compensation, leadership structures in hospitals and models for the delivery of care. As physicians integrate with hospitals, many take on leadership roles and begin to play a larger role in the hospital's decision-making.

Physicians' motivations for hospital employment include a desire for greater stability, improved work-life balance and fewer administrative duties associated with running a practice. For some physicians, these benefits outweigh compensation concerns. A study by PricewaterhouseCoopers found that 17 percent of physicians said they would take a decrease in compensation in exchange for hospital employment.

Hospitals' primary motivation for employing physicians is to increase market share and revenue, according to a study by the Center for Studying Health System Change. Other reasons for employing physicians include integrating care to prepare for accountable care organizations, patient-centered medical homes and other models under healthcare reform and creating greater efficiencies.

Two of the year's notable transactions between hospitals and physician practices involved Lourdes Health System in Camden, N.J., and two cardi-

ology groups. In January, Lourdes acquired Associated Cardiovascular Consultants, a 31-physician practice. In July, the health system acquired South Jersey Heart Group, which included 17 cardiologists and five offices. Another significant transaction was between Wilkes-Barre (Pa.) General Hospital and multispecialty practice Intermountain Medical Group in January. Wilkes-Barre General Hospital acquired the group, which was comprised of 52 physicians and nearly 30 locations, including a diagnostic imaging center, diagnostic lab, physician therapy center and sleep lab.

9. Increased scrutiny on hospitals' tax-exempt status.

The year also brought several developments regarding non-profit hospitals' tax-exempt status. The PPACA placed several new requirements on tax-exempt hospitals, and guidance on one of the most notable new requirements — the community health needs assessment — was issued by the Internal Revenue Service in July. Hospitals must perform a needs assessment every three years and develop plans for addressing the needs or face a \$50,000 fine. Other new regulations require hospitals to develop a written financial assistance policy and distribute it to patients; limit charges for uninsured and patients receiving financial assistance; and cease extraordinary debt collection practices. The new reporting requirements, which will be incorporated into hospitals' IRS Form 990 Schedule H, are intended to allow Congress the opportunity to examine the data and interpret whether hospitals have provided an appropriate level of community benefit to maintain tax-exempt status. Currently, the IRS is simply assessing whether a hospital has met the new requirements on a binary basis (i.e., Did the hospital facility conduct a health needs assessment?). Thus, hospitals can, for the near future, protect their tax-exempt status by ensuring they can "check yes" on each of the reported measures. However, if Congress decides that community benefit levels are not equivalent to tax-exempt benefits, it could mandate minimum thresholds of community benefit, which would be a major threat to many hospitals' tax statuses.

Hospitals should also plan for increased scrutiny on the state level, especially as many states face budget shortfalls and are looking for additional sources of revenue. Illinois caused a stir in the hospital industry in August when the state's Department of Revenue denied property tax exemptions to three hospitals in the state: Northwestern Memorial's Prentice Women's Hospital in Chicago, Edward Hospital in Naperville and Decatur (Ill.) Memorial Hospital. Shortly thereafter, the Department announced plans to reexamine the tax-exempt status of 15 other hospitals in the state based on how much charity care they provide. The denials followed a 2010 ruling by the Illinois Supreme Court that upheld the revocation of Provena Covenant Medical Center's tax-exempt status for providing too little charity care. In September, Illinois Gov. Pat Quinn halted the 15 investigations saying the Depart-

ment should wait until the state legislature issues recommendations on charity care levels.

10. Increased fraud prosecution. With the Obama administration's intense focus on fraud-fighting efforts, healthcare fraud prosecution has ballooned. Statistics released in August showed a 24 percent increase in fraud prosecutions in the first eight months of 2011 compared to the same time in fiscal year 2010. Convictions are also on the rise. There were already 24 trial convictions from the first eight months of 2011, while the entire year of 2010 saw only 23.

Along with these statistics reflecting increased prosecution, there were several record-setting breakthroughs for federal enforcement in 2011. In February, 111 physicians, nurses and other defendants nationwide were charged in the largest healthcare fraud takedown to date, executed by the Medicare Fraud Strike Force. The defendants were accused of schemes involving more than \$225 million in false billing, along with kickbacks and money laundering. Soon after announcing the record-breaking takedown, the task force expanded their operations to two additional cities: Dallas and Chicago. And in September, a Miami man who pled guilty to a \$205 million Medicare fraud scheme was sentenced to 50 years in prison — the longest sentence ever imposed in a Medicare Fraud Strike Force case. Lawrence Duran, the owner of American Therapeutic Corporation, billed Medicare for services that were not medically necessary from 2002-2010. Department of Justice officials said his sentence "reflects the reprehensibility" of his conduct.

In the past year, large, prominent hospitals and systems have also been involved in healthcare fraud lawsuits or settlements. In February, Catholic Healthcare West paid \$9.1 million to settle allegations that seven of its hospitals had submitted fraudulent claims to Medicare. In April, Dartmouth-Hitchcock Medical Center in Lebanon, N.H., agreed to pay \$2.2 million to settle allegations that it improperly billed various federal health programs from 2001-2007. Also in April, Louisville, Ky.-based Norton Healthcare paid the federal government nearly \$783,000 to settle claims that it overbilled Medicare for certain services. ■

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From Treating the Sick to Managing Community Health: Hospitals' New Role in Managing Population Health (continued from page 1)

managers to coordinate care for specific patient populations, particularly those with chronic diseases, and oversee care for a variety of patients outside the traditional walls of a hospital. In the past, care coordination and population health management was relegated to the most sophisticated integrated delivery health networks with significant managed-care contracts or safety-net and other hospitals in low-income communities whose missions are deeply guided by community health improvement. However, healthcare reform legislation and other catalysts are beginning to pressure hospitals to take a broader view toward their role in community health. Systems and facilities of all sizes that have long been focused on providing high quality care *in* the hospital must now turn toward keeping patients *out* of the hospital, and the transition won't be an easy one for many.

"Among providers, there is a growing recognition that payment is going to change. There will be less money to go around, and it will be distributed in a dramatically different way than in the past," says Brad Benton, KPMG Healthcare's national account leader. "How hospitals orient away from volume and toward health will be a critical success factor."

Why now?

Efforts to drive down skyrocketing health costs, driven by an aging population and new technologies, came to a head in March of 2010 when President Barack Obama signed into law the Patient Protection and Affordable Care Act. The law most notably includes significant insurance reforms, but also sets in motion several programs that begin to transition the healthcare delivery system away from fee-for-service payments and toward those based on performance. In addition to reimbursement reforms that take into account quality and readmissions, CMS will launch an expanded bundled payment program as well as programs aimed at developing accountable care organizations and patient-centered medical homes. And, it's not just public payors. In fact, many private payors are ahead of CMS in regards to developing shared savings and bundled programs with providers that incent coordinated, high-quality care. While these programs don't go as far as fully capitated payments, they do suggest that greater accountability, and financial risk, will be required by providers. So what does this mean for health systems? For many, it means their role in managing population health will move beyond disparate programs aimed at addressing specific community needs as part of their community benefit efforts to integrated programs that allow the system to oversee, and be financially responsible for, a patient's entire continuum of care.

Hospitals' new role

Being able to take on financial risk for population health management means a number of things for a hospital system: control of partnerships with physicians, post-acute providers and others along the continuum of care; resources and expertise to reduce variability among providers, better coordinate services and reduce readmissions; health information systems to track large amounts of data on care quality and costs; and robust analytics programs to assess risk and price services. Different risk models require different capabilities — for example, shared savings models require less integration and coordination than fully capitated models — but at the minimum this new way of delivery care requires alignment with physicians, evidence-based clinical care pathways and IT systems to track adherence to pathways, quality and patient satisfaction changes and determine any financial incentives. In the future, more robust capabilities may be required if care continues to move toward more fully capitated models built around managing a population's health.

"As we think about the conversation around healthcare reform, one mandate is the move away from fee-for-service, individual care toward assessing and managing the health of a community," says Alan Channing, president and CEO of Sinai Health System on Chicago's lower-income west side.

"Managing the patient appropriately with the best care the first time always is the thing that is going to create the greatest cost savings," says Tamara Sheffield, MD, medical director of community health and prevention of Salt Lake City-based Intermountain Healthcare. "You can't get [adequate cost reductions] without expense management. You have to have a very close relationship with physicians and share both upside and downside incentives." Intermountain, which began as a hospital-only operator, began its journey toward a fully integrated health network in the 1980s. The system's reasoning for the integration, says Dr. Sheffield, was to improve clinical information management, which allowed the organization to develop care process models, improve decision-making, coordinate care and drive out costs. Hospitals that plan to take on risk need to be able to consider how their organization will support such systems. "What tools, what prompts do you need? How do you make collective choices?" she asks.

Today every patient that presents to one of Intermountain's clinics or hospitals is enrolled in what the system calls a "care process model," which uses evidence-based guidelines to prompt clinicians toward the most appropriate care. Clinicians' adherence to the CPMs is tracked, and they are rewarded for meeting certain metrics within them. The most common diagnoses have their own CPM, and CPMs aren't limited to inpatient care — they also cover chronic disease management in the primary care setting as well as preventive issues, such as weight management and smoking cessation.

Pre-primary care

While most current care coordination efforts are focused on acute, post-acute and primary care, riskier models that oversee larger portions of the care continuum will require systems to become adept at providing what Mr. Channing calls "pre-primary care" services. Pre-primary care — which Mr. Channing says is where the most cost control can take place — refers to programs and other efforts ranging from nutrition and fitness programs to more coordinated preventative health initiatives aimed at keeping patients healthy.

Non-profit Sinai has offered such programs through its Sinai Urban Health Institute and Sinai Community Institute. The Sinai Urban Health Institute performs translational research and, as part of that, deploys community health workers to educate asthmatic children and their parents about the condition with the goal of reducing ER visits and admissions. Meanwhile, Sinai Community Institute addresses the social issues which have a big impact on health. For example, it runs a peer-education program aimed at reducing unplanned teen pregnancies. Both programs have rigorous evaluations and documented outcomes.

Parkview Health in Fort Wayne, Ind., is another hospital experienced at offering pre-primary care services. Its community nursing program was the recipient of this year's American Hospital Association NOVA Award for improving community health. The program deploys nurses to schools and other locations in the community to educate patients and help manage their conditions along care plans, says Connie Kerrigan, RN, manager of community nursing and women's health at Parkview. In regards to Parkview's community health programs, Ms. Kerrigan says, "We aim to understand what's happening in our community, and then see how the gaps we're witnessing could be filled."

While a future where health systems are financially responsible to provide impactful pre-primary care may seem daunting, those experienced in these efforts say much of a hospital's burden can be lessened through partnerships that may include cost-sharing with the health department, free clinics and other community groups. "A lot of what we do is working with other people in our community and determining how we, together, can have the best impact and what role we play as a community health organization," says Ms. Kerrigan.

Most hospitals currently tend to view pre-primary care programs under the umbrella of "community benefit," but as hospitals take on risk arrange-

ments, the impact of these programs may no longer be optional. As this transition occurs, Mr. Channing cautions hospitals to carefully measure and analyze outcomes from these programs to determine if the level of health improvement is worth the cost. "Across all of our activities, we try to be as rigorous in terms of measurement of outcomes as we can be. We want to know when something we have done makes a difference," he says.

KPMG's Mr. Benton agrees. "Hospitals have to evaluate the depth of these programs [through data]," he says. "Are we meaningfully affecting key cost drivers? What economic successes emerge from these programs?"

Balancing the transition

While no one disputes community health programs and care processes are valuable, developing them can be challenging for hospitals. In order to be successful, physicians need to play a role in creating and deploying them, and physicians are already pressed for time. Additionally, reimbursement can be an issue. Health systems with bundled or capitated payments essentially absorb the cost of the programs, but can benefit financially from them if they drive down costs compared to the contracted rate. In fact, KPMG's Mr. Benton says it may be possible for the most advanced systems to actually have higher profit margins under these new models, even with lower revenues.

It gets trickier under fee-for-service agreements, which by far represent the majority of contracts. While some commercial payors and soon CMS will partner with hospitals in fee-for-service agreements that share cost savings in order to incentivize care coordination, hospitals without such partnerships face a dilemma: How does it all get paid for? Care coordination takes a significant amount of time and effort, and beyond that, not all services physicians plan to include on care process models may be eligible for reim-

bursement under current contracts. Health systems face challenging times ahead as they will likely have to manage both fee-for-service and various pay-for-performance contracts at the same time.

"The real question is how do you move from that approach to more of a mainstream funding mechanism [to one] that allows you to think about managing the health of a population more holistically?" says Mr. Channing. "We're currently in discussions to incorporate our community health programs in a model within a risk-managed environment. We believe strongly that everyone should have a medical home and access to health education services, but there is a lot of front-end work that has to be done to develop that, and we strongly believe the managed care community has to help us develop it to be successful."

What will the future of healthcare delivery look like?

Most healthcare experts agree that the healthcare delivery system of the future will be very different than the fee-for-service system of today. Rising healthcare costs, growing federal debt and consumers' more active role in seeking out high-quality, affordable care will demand it. However, there is a multitude of ways to pay for and create a pay-for-performance-based healthcare system.

The specific ways health systems will adapt are yet to be determined. "I expect we could see a different model in every community," says Mr. Channing. "I think there will be a natural coming together of hospitals in the community with post-acute care providers and others to think about how to allocate resources, save money and generate a margin that can be rein-



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vested in the community. The differences will come out depending on who has the resources and passion to drive it forward.”

KPMG's Mr. Benton predicts that in some markets it may be payors or other intermediaries who are driving care coordination, either on their own through acquiring providers or through collaborative partnerships with health systems to care for certain patient populations. “In order to manage risk effectively, certain assets are required that, in many cases, are not currently present in all but the most integrated provider systems,” he says.

Even if provider organizations desired to develop these assets, the capital costs associated with them could be too much to bear. “A health system really has to look in the mirror and understand what its appetite for risk is,” says Mr. Benton. “After they have a very credible assessment of its [risk] appetite, systems need to examine their current ability to manage that risk, identify any gaps and see how these ideas fit with current business planning.”

No matter how the final arrangements flesh out, Mr. Channing worries that determining how to divide payments among providers will be a major stumbling block. “It's going to be a contest between the various players over who gets what dollars and who invests what,” he says. “It will be a distraction, but we have to get past that and think instead about how we are going to make a difference in the health of the community.”

Intermountain's Dr. Sheffield sees yet another challenge: Patients are largely left out of the incentive equation. Both providers and payors have an inherent incentive to bring down costs under new payment models, but most reform efforts don't provide incentives to the patient for healthy behavior. “I think hospitals need to find ways to incentivize patients to make appropriate choices for themselves,” she says. In her experience, close partnerships with a health plan are needed to coordinate such an incentive. ■

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200 Hospital Benchmarks

200 Hospital Benchmarks

Hospitals are constantly striving to improve their finances, operations and quality, but they need the proper metrics to turn those good intentions into measurable action. *Becker's Hospital Review* has collected 200 benchmarks from various healthcare organizations for hospitals to measure their performance. Where does your hospital stand? *Note: Unless otherwise noted, benchmarks represent national averages.*

Quality Benchmarks

Outcomes of Care Benchmarks

Mortality rates represent the percentage of patients who die within 30 days of their admission to a hospital. Readmission rates represent the percentage of patients who have had a recent hospital stay and need to go back into a hospital again within 30 days of their discharge.¹

- Heart attack mortality rate
(Sample size: 4,311 hospitals)
 - 25th percentile — 14.8 percent
 - Median — 15.7 percent
 - Average — 15.79 percent
 - 75th percentile — 16.8 percent
- Heart attack readmission rate
(Sample size: 4,248 hospitals)
 - 25th percentile — 19 percent
 - Median — 19.8 percent
 - Average — 19.88 percent
 - 75th percentile — 20.7 percent
- Heart failure mortality rate
(Sample size: 4,427 hospitals)
 - 25th percentile — 10.4 percent
 - Median — 11.3 percent
 - Average — 11.39 percent
 - 75th percentile — 12.3 percent
- Heart failure readmission rate
(Sample size: 4,433 hospitals)
 - 25th percentile — 23.5 percent
 - Median — 24.7 percent
 - Average — 24.86 percent
 - 75th percentile — 26.1 percent
- Pneumonia 30-day mortality rate
(Sample size: 4,445 hospitals)
 - 25th percentile — 10.7 percent
 - Median — 11.8 percent
 - Average — 11.96 percent
 - 75th percentile — 13 percent
- Pneumonia readmission rate
(Sample size: 4,446 hospitals)
 - 25th percentile — 17.4 percent
 - Median — 18.3 percent
 - Average — 18.45 percent
 - 75th percentile — 19.4 percent

Process of Care Measures

Measures how often hospitals provide some of the care that is recommended for patients with a heart attack, heart failure, pneumonia, surgery and children's asthma.²

- Outpatients having surgery who received an antibiotic at the right time (within one hour before surgery) — 93 percent
- Outpatients having surgery who received the right kind of antibiotic — 94 percent
- Surgery patients who were taking beta blockers before coming to the hospital who were kept on beta blockers during the periods prior and following their surgery — 93 percent
- Surgery patients who were given an antibiotic at the right time (within one hour before surgery) — 97 percent
- Surgery patients who were given the right kind of antibiotic to prevent infection — 97 percent
- Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) — 95 percent
- Heart surgery patients whose blood sugar was kept under control in the days immediately following surgery — 94 percent
- Surgery patients needing their hair removed from the surgical area before surgery who underwent hair removal using a safe method (such as electric clippers or hair removal cream opposed to razors) — 100 percent
- Surgery patients whose urinary catheters were removed on the first or second day after surgery — 91 percent
- Surgery patients whose physicians ordered treatments to prevent blood clots after certain types of procedures — 94 percent
- Patients who received treatment at the right time (within 24 hours before or after surgery) to help prevent blood clots after certain types of surgery — 93 percent
- Average number of minutes before outpatients with chest pain or possible heart attack patients were transferred to another hospital — 61 minutes
- Average number of minutes before outpatients with chest pain or possible heart attack received an ECG — 8 minutes
- Outpatients with chest pain or possible part attack patients who received drugs to break up blood clots within 30 minutes of arrival — 55 percent

21. Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival — 95 percent
22. Heart attack patients given aspirin at arrival — 99 percent
23. Heart attack patients given aspirin at discharge — 99 percent
24. Heart attack patients given ACE inhibitor or ARB for left ventricular systolic dysfunction — 96 percent
25. Heart attack patients given smoking cessation advice/counseling — 100 percent
26. Heart attack patients given beta blocker at discharge — 98 percent
27. Heart attack patients given fibrinolytic medication within 30 minutes of arrival — 57 percent
28. Heart attack patients given PCI within 90 minutes of arrival — 90 percent
29. Pneumonia patients assessed and given pneumococcal vaccination — 93 percent
30. Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics — 96 percent
31. Pneumonia patients given smoking cessation advice/counseling — 97 percent
32. Pneumonia patients given initial antibiotics within six hours after arrival — 95 percent
33. Pneumonia patients given the most appropriate initial antibiotics — 92 percent
34. Pneumonia patients assessed and given influenza vaccination — 91 percent
35. Heart failure patients given discharge instructions — 89 percent
36. Heart failure patients given an evaluation of left ventricular systolic function — 98 percent
37. Heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction — 95 percent
38. Heart failure patients given smoking cessation advice/counseling — 99 percent
39. Children who received reliever medication while hospitalized for asthma — 100 percent
40. Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma — 100 percent

41. Children and their caregivers who received a home management health plan of care document while hospitalized for asthma — 74 percent

Accountability Measures

Accountability composite measures are calculated by adding the number of times recommended care was provided over all the process measures in the given measure set, then dividing this sum by the total number of opportunities for providing this recommended care. The composite measure shows the percentage of the time the recommended care for each condition was provided.³

42. Heart attack care composite — 98.3 percent
43. Pneumonia care composite — 94.6 percent
44. Surgical care composite — 92.3 percent
45. Children's asthma care composite — 92.3 percent

Patient Experience Benchmarks

Figures reflect measures from the Hospital Consumer Assessment of Healthcare Providers and Systems.

How do patients rate hospital overall?

Answers reflect a 1-10 scale, with 10 being the best. Sample size: 3,811 hospitals.

46. Patients who gave rating of 6 or lower
 - 25th percentile — 6 percent
 - Median — 8 percent
 - Average — 8.91 percent
 - 75th percentile — 11 percent
47. Patients who gave rating of 7 or 8
 - 25th percentile — 20 percent
 - Median — 24 percent
 - Average — 23.65 percent
 - 75th percentile — 27 percent
48. Patients who gave rating of 9 or 10
 - 25th percentile — 62 percent
 - Median — 68 percent
 - Average — 67.44 percent
 - 75th percentile — 73 percent

How often did physicians communicate well with patients?

Sample size: 3,812 hospitals

49. Physicians 'always' communicated well
 - 25th percentile — 77 percent
 - Median — 80 percent
 - Average — 80.25 percent
 - 75th percentile — 84 percent

50. Physicians 'sometimes' or 'never' communicated well
 - 25th percentile — 3 percent
 - Median — 4 percent
 - Average — 4.58 percent
 - 75th percentile — 6 percent

51. Physicians 'usually' communicated well
 - 25th percentile — 13 percent
 - Median — 15 percent
 - Average — 15.17 percent
 - 75th percentile — 18 percent

How often did nurses communicate well with patients?

Sample size: 3,812 hospitals

52. Nurses 'always' communicated well
 - 25th percentile — 73 percent
 - Median — 76 percent
 - Average — 76.01 percent
 - 75th percentile — 80 percent

53. Nurses 'sometimes' or 'never' communicated well
 - 25th percentile — 3 percent
 - Median — 5 percent
 - Average — 5.28 percent
 - 75th percentile — 7 percent

54. Nurses 'usually' communicated well
 - 25th percentile — 16 percent
 - Median — 19 percent
 - Average — 18.71 percent
 - 75th percentile — 21 percent

How often did patients receive help quickly from hospital staff?

Sample size: 3,812 hospitals

55. Patients 'always' received help as soon as they wanted
 - 25th percentile — 58 percent
 - Median — 63 percent
 - Average — 64.08 percent
 - 75th percentile — 70 percent

56. Patients 'sometimes' or 'never' received help as soon as they wanted
 - 25th percentile — 7 percent
 - Median — 10 percent
 - Average — 10.66 percent
 - 75th percentile — 14 percent

57. Patients 'usually' received help as soon as they wanted
 - 25th percentile — 23 percent
 - Median — 26 percent
 - Average — 25.26 percent
 - 75th percentile — 29 percent

How often did staff explain about medicines before giving them to patients?

Sample size: 3,808 hospitals

58. Staff 'always' explained
 - 25th percentile — 57 percent
 - Median — 60 percent
 - Average — 60.57 percent
 - 75th percentile — 64 percent

59. Staff 'sometimes' or 'never' explained

- 25th percentile — 18 percent
- Median — 21 percent
- Average — 21.1 percent
- 75th percentile — 24 percent

60. Staff 'usually' explained

- 25th percentile — 17 percent
- Median — 18 percent
- Average — 18.34 percent
- 75th percentile — 20 percent

How often was patients' pain well controlled?

Sample size: 3,811 hospitals

61. Pain was 'always' well controlled

- 25th percentile — 66 percent
- Median — 69 percent
- Average — 69.35 percent
- 75th percentile — 72 percent

62. Pain was 'sometimes' or 'never' well controlled

- 25th percentile — 5 percent
- Median — 7 percent
- Average — 7.21 percent
- 75th percentile — 8 percent

63. Pain was 'usually' well controlled

- 25th percentile — 21 percent
- Median — 24 percent
- Average — 23.44 percent
- 75th percentile — 26 percent

How often was the area around the patient rooms kept quiet at night?

Sample size: 3,812 hospitals

64. 'Always' quiet at night

- 25th percentile — 51 percent
- Median — 58 percent
- Average — 58.11 percent
- 75th percentile — 65 percent

65. Pain was 'sometimes' or 'never' quiet at night

- 25th percentile — 7 percent
- Median — 11 percent
- Average — 11.46 percent
- 75th percentile — 15 percent

66. Room was 'usually' quiet at night

- 25th percentile — 27 percent
- Median — 31 percent
- Average — 30.43 percent
- 75th percentile — 35 percent

How often were patient rooms and bathrooms kept clean?

Sample size: 3,812 hospitals

67. Room was 'always' clean

- 25th percentile — 66 percent
- Median — 71 percent
- Average — 71.35 percent

• 75th percentile — 76 percent

68. Room was 'sometimes' or 'never' clean

- 25th percentile — 6 percent
- Median — 9 percent
- Average — 9.20 percent
- 75th percentile — 12 percent

69. Room was 'usually' clean

- 25th percentile — 17 percent
- Median — 20 percent
- Average — 19.45 percent
- 75th percentile — 23 percent

Were patients given information about what to do during their recovery at home?

Sample size: 3,809 hospitals

70. No, staff 'did not' give patients this information

- 25th percentile — 15 percent
- Median — 17 percent
- Average — 17.94 percent
- 75th percentile — 21 percent

71. Yes, staff 'did' give patients this information

- 25th percentile — 79 percent
- Median — 83 percent
- Average — 82.06 percent
- 75th percentile — 85 percent

Would patients recommend the hospital to friends and family?

Sample size: 3,811 hospitals

72. No, patients probably would not or definitely would not recommend the hospital

- 25th percentile — 3 percent
- Median — 5 percent
- Average — 5.32 percent
- 75th percentile — 7 percent

73. Yes, patients would definitely recommend the hospital

- 25th percentile — 63 percent
- Median — 70 percent
- Average — 69.46 percent
- 75th percentile — 76 percent

74. Yes, patients would probably recommend the hospital

- 25th percentile — 20 percent
- Median — 25 percent
- Average — 25.23 percent
- 75th percentile — 30 percent

Patient Satisfaction Benchmarks

Responses are based on 100-point scales, with 100 reflecting "very good," 50 reflecting "fair" and 0 reflecting "very poor."

75. Overall patient satisfaction score for hospital with 1-50 beds — 88.3

76. Overall patient satisfaction score for hospital with 51-149 beds — 86.1

77. Overall patient satisfaction score for hospital with 150-299 beds — 84.9

78. Overall patient satisfaction score for hospital with 300-449 beds — 84.5

79. Overall patient satisfaction score for hospital with 450-600 beds — 84.5

80. Overall patient satisfaction score for hospital with 600+ beds — 84.4

81. Overall patient satisfaction score for admission through hospital ED — 83.2

82. Overall patient satisfaction score for admission not through ED — 86.1

Physician Satisfaction Benchmarks

Responses are based on 100-point scales, with 100 reflecting "very good," 50 reflecting "fair" and 0 reflecting "very poor."

83. Overall physician satisfaction score — 73.4

84. Overall physician satisfaction score with patient care — 78.9

85. Overall physician satisfaction score with ease of practice — 77.3

86. Overall physician satisfaction score with relationship with leaders — 66.2

87. Overall physician satisfaction score with overall assessment — 77.6

Financial Benchmarks

Data is derived from a sample of 1,144 hospitals.⁷

88. Average net patient revenue — \$244,218

89. Average operating margin — 1.26

90. Average profit margin — 3.43

91. Average days cash on hand — 144.8

92. Average days in accounts receivable — 46.5

93. Average number of admissions per year — 11,332

94. Average number of beds in service — 216

95. Average number of patient days — 53,529

96. Average number of outpatient visits — 196,807

97. Average number of inpatient surgical operations — 3,198

98. Average number of outpatient surgical operations — 5,767

99. Average FTE employees — 1,346

100. Average hourly wage — \$12



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101. Net accounts receivable — \$29,787
102. Long-term debt — \$78,524
103. Average depreciation and amortization expense — \$12,793

Quartiled Financial Benchmarks⁸

104. Total profit margin, all hospitals
- 1st Quartile — 13.40 percent
 - 2nd Quartile — 4.85 percent
 - 3rd Quartile — 0.57 percent
 - 4th Quartile — -6.80 percent
105. Total profit margin, non-profit hospitals
- 1st Quartile — 11.42 percent
 - 2nd Quartile — 4.04 percent
 - 3rd Quartile — 0.15 percent
 - 4th Quartile — -7.04 percent
106. Total profit margin, investor-owned hospitals
- 1st Quartile — 19.16 percent
 - 2nd Quartile — 10.43 percent
 - 3rd Quartile — 4.30 percent
 - 4th Quartile — -4.48 percent

107. Total operating profit margin, all hospitals
- 1st Quartile — 12.32 percent
 - 2nd Quartile — 2.24 percent
 - 3rd Quartile — -2.91 percent
 - 4th Quartile — -11.94 percent

108. Total operating profit margin, investor-owned hospitals
- 1st Quartile — 20.03 percent
 - 2nd Quartile — 10.48 percent
 - 3rd Quartile — 2.85 percent
 - 4th Quartile — -7.79 percent

109. Total operating profit margin, non-profit hospitals
- 1st Quartile — 9.60 percent
 - 2nd Quartile — 1.71 percent
 - 3rd Quartile — -2.54 percent
 - 4th Quartile — -10.89 percent

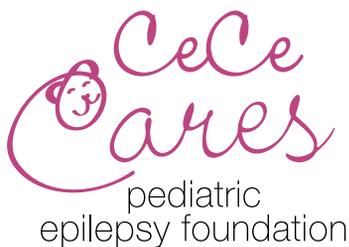
110. Days net patient revenue in accounts receivable, all hospitals
- 1st Quartile — 33.71 days
 - 2nd Quartile — 44.91 days
 - 3rd Quartile — 53.16 days
 - 4th Quartile — 70.26 days

111. Days net patient revenue in accounts receivable, investor-owned hospitals
- 1st Quartile — 35.31 days
 - 2nd Quartile — 45.42 days
 - 3rd Quartile — 53.21 days
 - 4th Quartile — 70.09 days

112. Days net patient revenue in accounts receivable, non-profit hospitals
- 1st Quartile — 32.36 days
 - 2nd Quartile — 43.26 days
 - 3rd Quartile — 50.64 days
 - 4th Quartile — 65.65 days

113. Total labor costs as percentage of net operating revenues, all hospitals
- 1st Quartile — 37.97 percent
 - 2nd Quartile — 45.71 percent
 - 3rd Quartile — 51.58 percent
 - 4th Quartile — 59.40 percent

114. Total labor costs as percentage of net operating revenues, investor-owned hospitals
- 1st Quartile — 34.05 percent
 - 2nd Quartile — 39.04 percent
 - 3rd Quartile — 44.26 percent
 - 4th Quartile — 53.87 percent



The CeCe Cares Pediatric Epilepsy Foundation is a national organization whose mission is to provide comfort to children diagnosed with epilepsy, help families burdened with the associated cost of medical care and raise funds for research — one CeCe Bear® at a time.

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INDIVIDUAL SUPPORT

If you have personally been touched by epilepsy, please consider giving to the CeCe Cares Pediatric Epilepsy Foundation. The cost to sponsor a CeCe Bear® is \$39.99. Whether you sponsor 1 bear or 100 bears, each CeCe Bear® sponsored provides:

- A large, 22" CeCe Bear® donated to a child diagnosed with epilepsy
- Financial grants to help parents pay for medical care
- Clinical research grants to help find a cure

CONTACT

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 Phone: (312) 428-3656
 Fax: (312) 428-8365
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www.cececares.org

115. Total labor costs as percentage of net operating revenues, non-profit hospitals
- 1st Quartile — 41.26 percent
 - 2nd Quartile — 46.22 percent
 - 3rd Quartile — 50.29 percent
 - 4th Quartile — 56.77 percent

Hospital Merger & Acquisition Benchmarks

Applies to acquisitions announced, not closed.⁹

116. Average price per bed in 2010 — \$427,000
117. Average price per bed in 2009 — \$398,000
118. Average price to revenue in 2010 — 0.7 times
119. Average price to revenue in 2009 — 0.78 times

Operational Benchmarks

Inpatient Benchmarks¹⁰

120. Average length of stay in days — 4.6
121. Hospital stays accounted for by Medicaid — 14 percent
122. Hospital stays accounted for by Medicare — 46 percent
123. Hospital stays accounted for by private insurance — 32 percent
124. Hospital stays accounted for by uninsured — 4 percent
125. Hospital stays accounted for by patients 65-84 years old — 35 percent
126. Average cost per discharge¹¹ — \$9,100
127. Average cost per discharge for patients <1 — \$3,600
128. Average cost per discharge for patients 1-17 — \$7,300-\$7,800 (range due to maternal and neonatal discharges)

129. Average cost per discharge for patients 18-44 — \$6,700-\$9,100 (range due to maternal and neonatal discharges)
130. Average cost per discharge for patients 45-64 — \$11,600
131. Average cost per discharge for patients 65-84 — \$11,900
132. Average cost per discharge for patients 85+ — \$9,400

Full-Time Equivalent and Facility Benchmarks¹²

133. Full-time equivalent staff per adjusted occupied bed, all hospitals
- 1st Quartile — 3.45 FTE
 - 2nd Quartile — 4.37 FTE
 - 3rd Quartile — 5.12 FTE
 - 4th Quartile — 6.48 FTE
134. Full-time equivalent staff per adjusted occupied bed, investor-owned hospitals
- 1st Quartile — 3.21 FTE
 - 2nd Quartile — 3.93 FTE
 - 3rd Quartile — 4.51 FTE
 - 4th Quartile — 5.76 FTE
135. Full-time equivalent staff per adjusted occupied bed, non-profit hospitals
- 1st Quartile — 3.61 FTE
 - 2nd Quartile — 4.55 FTE
 - 3rd Quartile — 5.27 FTE
 - 4th Quartile — 6.55 FTE
136. Average age of plant, all hospitals
- 1st Quartile — 3.63
 - 2nd Quartile — 7.70
 - 3rd Quartile — 10.59
 - 4th Quartile — 15.39
137. Average age of plant, investor-owned hospitals
- 1st Quartile — 2.12

- 2nd Quartile — 4.83
- 3rd Quartile — 8.23
- 4th Quartile — 12.96

138. Average age of plant, non-profit hospitals
- 1st Quartile — 4.90
 - 2nd Quartile — 8.65
 - 3rd Quartile — 11.28
 - 4th Quartile — 15.75

Census Disparity Index Benchmarks

Data highlights the gap between 24-hour census and midnight census, with lower percentages indicating less disparity. The index may be used to inform hospital leadership decisions about patient load measurement, budgeting and projection of staffing needs.¹³

139. Total — 25 percent
140. Cardiovascular — 21.95 percent
141. Critical care — 27.66 percent
142. Emergency department — 44.71 percent
143. Intensive care — 26.67 percent
144. Medical — 19.69 percent
145. Medical/surgical — 25.95 percent
146. Neonatal intensive care — 10.15 percent
147. Neurology — 27.24 percent
148. Oncology — 20.91 percent
149. Orthopedics — 23.38 percent
150. Pediatric intensive care — 29.48 percent
151. Pediatrics — 29.79 percent
152. Psychiatric — 13.38 percent
153. Rehabilitation — 12.25 percent
154. Respiratory — 12.25 percent
155. Surgical — 23.16 percent



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156. Telemetry — 25.91 percent

157. Women's and children's — 39.51 percent

Admissions, Discharges and Transfers Index Benchmarks

Data indicates the proportion of the unit's population that is turning over during a shift. Lower percentages indicate less flow. The ADT Index can be used to determine if there is a need to reallocate resources to better manage patient flow.¹⁴

158. Total — 26.11 percent

159. Cardiovascular — 27.56 percent

160. Critical care — 28.46 percent

161. Emergency department — 66.94 percent

162. Intensive care — 26.21 percent

163. Medical — 16.42 percent

164. Medical/surgical — 24.7 percent

165. Neonatal intensive care — 9.7 percent

166. Neurology — 28.06 percent

167. Oncology — 20.97 percent

168. Operating room — 71.45 percent

169. Orthopedics — 21.75 percent

170. Pediatric intensive care — 28.46 percent

171. Pediatrics — 28.02 percent

172. Psychiatric — 9.9 percent

173. Rehabilitation — 12.46 percent

174. Respiratory — 3.78 percent

175. Surgical — 26.71 percent

176. Telemetry — 51.64 percent

177. Women's and children's — 43.98 percent

Workload Contribution Factor Benchmarks

Data indicates the proportion of the unit's admission, discharge and transfer activity that is attributed to each component — admissions, discharges and transfers.¹⁵

178. Hospital-wide

- Day shift — 39.02 percent
- Evening shift — 22.41 percent
- Night shift — 17.8 percent

179. Cardiovascular

- Day shift — 49.93 percent
- Evening shift — n/a
- Night shift — 14.69 percent

180. Critical care

- Day shift — 42.04 percent
- Evening shift — n/a
- Night shift — 17.9 percent

181. Emergency department

- Day shift — 68.69 percent
- Evening shift — n/a
- Night shift — 18.44 percent

182. Intensive care

- Day shift — 37.47 percent
- Evening shift — 24.94 percent
- Night shift — 18.44 percent

183. Medical

- Day shift — 25.76 percent
- Evening shift — 18.55 percent
- Night shift — 9.34 percent

184. Medical/surgical

- Day shift — 35.83 percent
- Evening shift — 30.75 percent
- Night shift — 15.57 percent

185. Neonatal intensive care

- Day shift — 14.38 percent
- Evening shift — 8.33 percent
- Night shift — 6.11 percent

186. Neurology

- Day shift — 41.76 percent
- Evening shift — n/a
- Night shift — 18.95 percent

187. Oncology

- Day shift — 33.78 percent
- Evening shift — n/a
- Night shift — 12.86 percent

188. Operating room

- Day shift — 82.7 percent
- Evening shift — n/a
- Night shift — 49.29 percent

189. Orthopedics

- Day shift — 38.51 percent
- Evening shift — 18.84 percent
- Night shift — 9.89 percent

190. Pediatric intensive care

- Day shift — 41.89 percent
- Evening shift — n/a
- Night shift — 16.49 percent

191. Pediatrics

- Day shift — 43.09 percent
- Evening shift — 31.98 percent
- Night shift — 14.06 percent

192. Psychiatric

- Day shift — 18.72 percent
- Evening shift — 10.86 percent
- Night shift — 5.55 percent

193. Rehabilitation

- Day shift — 21.47 percent
- Evening shift — 13.37 percent
- Night shift — 6.16 percent

194. Respiratory

- Day shift — 5.91 percent
- Evening shift — n/a
- Night shift — 2.53 percent

195. Surgical

- Day shift — 39.98 percent
- Evening shift — 19.32 percent
- Night shift — 19.23 percent

196. Telemetry

- Day shift — 39.17 percent
- Evening shift — 25.43 percent
- Night shift — 16.08 percent

197. Women's and children's

- Day shift — 55.71 percent
- Evening shift — 37.8 percent
- Night shift — 35.61 percent

Emergency Department Benchmarks

198. Average time between patient entering ED and seeing physician — 56 minutes¹⁶

199. Average length of stay in ED — 4 hours, 7 minutes¹⁷

200. Average number of ED visits — 51,265¹⁸ ■

Source:

1 iVantage Health Analytics, Sept. 2011.

2 Hospital Compare, U.S. Department of Health & Human Services. Last updated Aug. 5, 2011.

3 The Joint Commission's Annual Report on Quality and Safety, 2011.

4 iVantage Health Analytics, Sept. 2011.

5 Press Ganey's 2010 Hospital Pulse Report.

6 Press Ganey's 2010 Hospital Pulse Report.

7 Merritt Research Services' 2010 Hospital Benchmarks.

8 The following data is from Healthcare Management Partners' HMP Metrics Quarterly Report, 2010, the latest data available. Quartile rankings were assigned based on mean values calculated for the hospitals within peer groups. The first quartile contains the top 25 percent of the best performing hospitals in an applicable peer group. The fourth represents those falling below 76 percent.

9 Irving Levin Associates, Inc.

10 Agency for Healthcare Research and Quality and its Healthcare Cost & Utilization Project, 2008.

11 Discharge refers to the hospital stay.

12 The following data is from Healthcare Management Partners' HMP Metrics Quarterly Report, 2010, the latest data available. Quartile rankings were assigned based on mean values calculated for the hospitals within peer groups. The first quartile contains the top 25 percent of the best performing hospitals in an applicable peer group. The fourth represents those falling below 76 percent. FTE reflects full-time equivalents.

13 OptiLink and Nursing Executive Center, The Advisory Board Company.

14 OptiLink and Nursing Executive Center, The Advisory Board Company.

15 OptiLink and Nursing Executive Center, The Advisory Board Company.

16 Centers for Disease Control and Prevention, 2010.

17 Press Ganey, Emergency Department Pulse Report, 2010.

18 Merritt Research Services' 2010 Hospital Benchmarks.

Opportunities in the New Bundled Payment Initiative

By Jonathan Pearce, Principal, Singletrack Analytics

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On Aug. 22, CMS release the details of the “Bundled Payments for Care Improvement Initiative” program, which is the lesser known of the two pilot programs implemented by the Patient Protection and Affordable Care Act health reform legislation. (The other pilot program, of course, is accountable care organizations.) The requirements for participation in this program, which were issued as a “request for application” rather than draft regulations, are remarkably clear, generally unambiguous and provide wide flexibility to providers interested in participating in this project. This is in contrast to the ACO draft regulations, which some observers believe are so complex, confusing and onerous that few participants are expected in that program. The application specifies four general models under which hospitals can participate, but within each category providers are allowed significant flexibility to propose a structure that will work well for them while meeting CMS’s goals. Many of the initial concerns raised about this program after passage of PPACA were alleviated by the level of flexibility allowed to participants.

Participation models

The initiative provides for four different models in which an organization can participate. These are:

- Model 1 – Retrospective payment for acute hospital stay only. For Model 1, letters of intent were due to CMS by Oct. 6 and completed applications are required by Nov. 18. (Note: CMS pushed back the original LOI and application dates of Sept. 22 and Oct. 21).

- Model 2 – Retrospective payment for physician and hospital services during an acute stay, including post-acute services. For Model 2-4, LOIs are due Nov. 4 and applications are required by March 15, 2012.
- Model 3 – Retrospective payment for post-acute services, not including the acute episode.
- Model 4 – Prospective payment for physician and hospital services for the acute stay.

A summary of the participation model characteristics is shown in Table 1 below.

Patients and services covered

Several characteristics are common to all models. First, each model is defined by the characteristics of patients who will be participating. In Model 1, all inpatients must participate, while in the remaining models the proposing organization can specify selected MS-DRG that will be included, while patients in other MS-DRGs will not be included.

Models are also defined by the services that are included in the bundled payment. In Model 1, only hospital party payments are included, while the other models include physician payments and, for Models 2 and 3, payments for post-acute services.

All patients involved in covered episodes at a participating hospital must be included in the bundled payment. There is no opportunity for a patient to “opt out,” or for the hospital or physi-

cian to exclude a particular patient in a bundled MS-DRG. This prevents “cream-skimming” that would occur if potentially high-cost patients could be excluded from the bundled payment.

Discounts and provider payments

Applicants for the program must provide CMS with a discount from the average aggregate payment amounts that would otherwise be paid for these patients on a fee-for-service basis. The amount of the discount is left to the applicant but obviously will be considered by CMS in selection of participants for the program. This discounted amount will become the fixed bundled payment that will be reconciled with FFS payments paid to providers under Models 1-3 and the amount paid to the contracting entity under Model 4.

The discount given is the “savings” that CMS recognizes from the initiative. There’s no further “shared savings” as occurs in ACOs and other similar programs. Instead, the providers’ compensation is the fixed bundled payment amount, regardless of what FFS payments would be for each patient. If the bundled payment exceeds the FFS amount, the providers retain the difference. If the FFS amount would exceed the bundled amount the providers lose the difference. This reduces the incentive for providers to provide unnecessary services [2] and may allow providers to reduce their costs without reducing their revenue.

In previous demonstration projects such as the Acute Care Episodes project, the bundled payment was made to the contracting organization, which was required to have the infrastructure to distribute payments to each of the providers

TABLE 1 - MODEL CHARACTERISTICS

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients	Selected MS-DRGs, plus post-acute	Post-acute only for selected MS-DRGs	Selected MS-DRGs
Services included in bundle	All Part A DRG-based payments	All services (hospital, physician, LTC, HHA, SNF, DME, Part B drugs, etc.)	Physician, hospital readmission, HHA, SNF, DME, Part B drug, etc.	Physician and hospital (including readmissions)
Payment type	Retrospective	Retrospective	Retrospective	Prospective

who provided services to the covered patients. This required these organizations to implement a significant claims payment infrastructure, which was burdensome to many providers, particularly to those without a significant proportion of employed physicians.

This requirement has been eliminated for Models 1-3, in which all providers will continue to be paid by CMS on a FFS basis. Periodic reconciliations will be performed to determine whether those payments were higher or lower than the bundled payment amount, and adjustment payments will be made by the organization or CMS as required to make the aggregate payments to the contracting organization equal the bundled amount. In Model 4 the bundled payment will be made to the organization, which is responsible for distributing those payments to the providers, who will not be paid by CMS for services to the included patients. CMS notes in several places in the application document that the contracting organization will be responsible for any payments in excess of the bundled amount, even if those payments were made to an unrelated provider (for example a non-participating physician or a readmission to a different hospital).

Gainsharing

In general, gainsharing payments to physicians who have created cost savings are allowed, since CMS is waiving several related regulations that cover hospital payments to physicians. Participation of physicians in gainsharing programs must be voluntary, and the organization must document the involvement of physicians in these cost saving processes as well as the payment methodology and the ways in which gainsharing will support care redesign to improve quality and create cost savings. Physicians must meet quality requirements before gain sharing payments can be made. Gainsharing payments to physicians cannot exceed 50 percent of the FFS-equivalent

payments that they would have received absent the bundled payment program, which is an increase from the 25 percent maximum that was used in the ACE demonstration. CMS apparently believes that greater sharing amounts are appropriate if the physicians significantly participate in the savings.

Quality measures

Maintenance and improvement of quality is a key characteristic of this program, and organizations are required to submit various quality metrics. Participating hospitals must have received their full IPPS and OPPI annual payment updates for reporting quality measures since at least FY 2009 and both hospitals and physicians must continue to participate in all quality reporting initiatives. However applicants are encouraged to propose new quality metrics in a wide variety of areas.

Participation in multiple CMS initiatives

The PPACA law specifies that organizations cannot participate in multiple "shared savings" programs of CMS. Therefore, there was some question as to whether a health system that was forming an accountable care organization could participate in the bundled payment pilot. CMS clarifies this issue in the application by stating that the bundled payment initiative program does not constitute a shared savings program and that organizations who form ACOs can still participate.

Episode Definition Models

The initiative defines the following four participation models:

Model 1

This model is designed primarily for hospitals to create internal cost savings that can be shared to physicians as part of gain sharing payments. It includes all inpatient admissions regardless of MS-DRGs but does not include physician services or post-acute.

Model 2

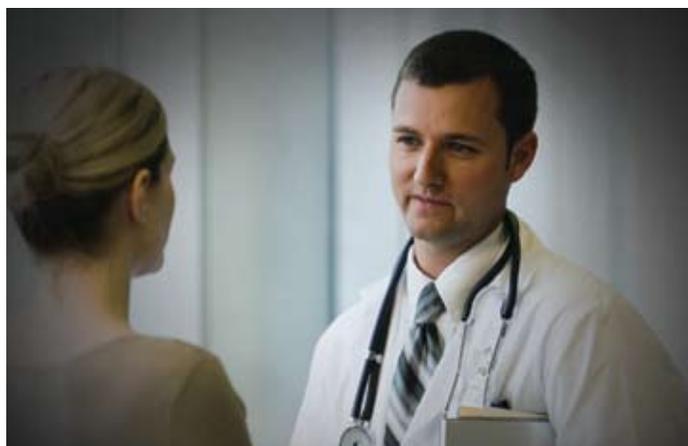
This is the model that was prescribed in the PPACA law. It includes the hospital and physician services and also acute and post-acute care. Applicants have two options to specify the post-acute episode; under the first option the episode it extends 30 to 89 days, while under the second option it extends 90 days or longer after the hospital discharge. Organizations selecting the second option are given flexibility to propose its definition. CMS's objective from this option is to explore ways in which patients can be transitioned back into the community, presumably from better discharge planning and postoperative care.

These rules clarify a major question that arose from the PPACA law by allowing the organization to select the MS-DRG to be included. Since the law was nonspecific, many readers were concerned that an organization would be required to participate in a specified list of MS-DRGs, including those for which their organizations not well-equipped to manage on a bundled basis. By allowing the organization to specify the MS-DRGs to be included, they can play to their strengths and include areas in which their physician relationships are strong, and in which significant cost savings are possible.

In addition, CMS is allowing organizations to propose further definitions of the episode; for example to exclude costs associated with unrelated readmissions. However, cost of readmissions, including physician services, must be included in the bundled payment.

Model 3

This model includes post-acute services only, with services provided at a SNF, inpatient rehab facility, LTAC or HHA for at least 30 days following an inpatient acute discharge. It also includes Part A and Part B payments for related readmissions. CMS will give preference to organizations proposing a longer period because of their interest in redesigning care to facilitate a patient's transition back into the community.



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Model 4

This model is generally a continuation of the Acute Care Episodes demonstration project with several exceptions. First, it allows the contracting organization to specify the MS-DRGs to be included (the ACE demo only included certain cardiac and orthopedic DRGs). It also will not limit participants to a specific demographic area (served by one Medicare Administrative Contractor) as the ACE demo did. Finally, CMS has eliminated the beneficiary cost savings component in which beneficiaries who utilized ACE-participating hospitals were given a credit on their Part B premiums. This feature was intended to create steerage to the ACE hospitals, but was apparently too burdensome to administer and was also confusing to the beneficiaries.

Similar to the ACE demo but different from the other models, the bundled payment will be paid directly to the contracting organization rather than to the individual providers. The contracting organization will then pay the providers based on whatever payment methodology has been developed. This avoids the need for periodic reconciliations with CMS but requires the organization to implement some form of claims payment infrastructure. This model may be attractive to current ACE participants who wish to continue with their existing infrastructure but does not appear to be as attractive to other participants who don't have this type of infrastructure in place.

The bundled payment business model

The effects of a bundled payment model are significantly different for those providers inside and outside of the contracting group. Those inside of the group have agreed to accept a fixed payment for a specific episode of care. Their compensation will be unrelated to the services that they provide to the patients. While they must maintain quality, they can reduce or eliminate services that are not necessary to proper patient care without any commensurate reduction in revenue as would occur under a FFS payment system.

Therefore, one of the incentives under a bundled payment model is for providers who are part of the contracting group to reduce their service level to those required for proper patient care. This will generally lower the providers' internal costs and/or make their time and resources available for other patients. This concept also extends to reducing readmissions and thereby the associated hospital and physician costs of treating those patients.

Another incentive is to reduce the utilization of providers outside of the contracting group. For example, in the CMS Heart Bypass demonstration project cardiac surgeons reduced the number of cardiology consults by performing those services themselves. This commensurately reduced FFS payments to the cardiologists, which left more of the bundled payment to be distributed among the providers in the contracting organization. (The cardiologists were understandably not pleased with this result.)

The third incentive is for hospitals and physicians to cooperate to reduce internal hospital costs (supplies, drugs, etc.) because the gainsharing features of the initiative allow those savings to be shared with the physicians who help create them. This process was quite successful for some hospitals in the ACE demonstration and resulted in significant savings for the hospitals, which were then shared with the physicians who helped create them.

Counterbalancing these positive incentives are two negative factors for participants. First, CMS requires contracting organizations to discount the bundled payment amount from the historical payments made for the proposed episodes. This means that the contracting providers must achieve cost reductions of several percent to break even. In addition, the contracting organization and its providers won't get paid more for complex cases, as they would under FFS payment. Not only will the contracting providers be a fixed amount to provide more services, but they will also be liable for any services rendered by providers outside of the contracting organization who will continue to be paid on a FFS basis. Therefore, the contracting organization's providers can have some significant risk exposure to high-cost cases, including outliers and readmissions.

This business model needs to be clearly understood by all participants since it's significantly different from the FFS models under which physicians generally operate. It creates additional risks, but also the opportunity for significant rewards for the participating physicians.

Episode and pricing analytics

Critical to the success of these organizations will be their ability to select, define and price the episodes of care that they propose. If carefully defined, the historical FFS provider payments for an episode should reasonably be predictable and stable, affected by factors that are identifiable and controllable, and provide an opportunity for cost reductions and quality improvements. Depending on the model, these payments can include physician payments, outlier payments to the hospital, payments to hospitals and physicians for related readmissions, post-acute providers, durable medical equipment and others.

To facilitate these analyses, CMS will allow organizations to request a "limited dataset" containing the relevant claims for the proposed model for 2008 and 2009. Organizations must complete a "Data Use Agreement" to allow this information to be released to them. The data will be supplied as up to seven multiple "Standard Analytical Files" containing multiple fields (the claims data contains 180 data fields) that must be merged together to consolidate all relevant claims. Once that database is built, episodes of care must then be constructed according to the definitions to be used by the proposing organization. The organization can then analyze this data to develop the episodes and pricing.

Hospital cost accounting data will also play a significant role in designing the proposal. Understanding the fixed and variable costs in each DRG will be important in determining the level of discount to propose for those DRGs. In addition, the components of all cost elements in each DRG form the basis of identifying opportunities for cost reductions in that DRG.

The analytics team

The team tasked with developing the CMS proposal and implementing the initiative if accepted by CMS, will require a wide range of skills in finance, clinical operations, medical decision-making, along with the analytical skills necessary to translate the information needs of the group into discrete analy-

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ses and reports. Physicians who specify patient treatment, use of ancillary services, consultations ordered and other similar cost-related decisions must work alongside the clinical managers of their departments who are knowledgeable about supply costs, staffing and department logistics. Finance staff members can work with cost accounting data to identify high-cost medical supplies or other cost drivers, particularly when their use varies based on the physician who orders them. The opportunity for gainsharing provides a unique framework for a multidisciplinary team to attack a common problem and create win-win solutions.

Opportunities to reduce hospital costs

This is the most attractive opportunity for several reasons. First, all of the parties benefit (other than the hospital's vendors) from cost reductions. Hospitals benefit directly, and physicians who create the savings can benefit through gainsharing. These savings also do not create reductions in payments to providers. To identify the possibilities of creating these savings, the analytics team should analyze the cost components of each DRG under consideration from the hospital cost accounting data. For example, significant cost savings have been recognized in ACE demonstration hospitals when orthopedists agreed to reduce the number of hip prostheses from 7 to 2. This reduced the number of vendors of prostheses and forced the remaining vendors to aggressively cut prices to maintain the hospitals business. This created significant savings which was shared with the orthopedists who participated in the process.

Opportunities to reduce payment variations

Some DRGs may not be judged suitable for inclusion in the initiative because of a high amount

of variation in provider payments across admissions. These variations may be caused by differences in length of stay (which may affect physician payments even though it doesn't affect DRG payments), outlier payments or readmissions, or varying use of post-acute services in Models 2 or 3. Even if the proposed bundled payment rate is established at the average payment amount, the variation between admissions within that DRG may be so high as to cause an unacceptable level of risk. The analytics team should review these variations, assess their causes and determine if they can be reduced. For example, the rate of readmissions may be reduced by careful post-discharge planning, which would reduce the variability caused by those payments. Reducing the variation generally has the effect of lowering the costs.

Opportunities to reduce provider payments through utilization reductions

Payments to all providers represent a charge against the bundled payment budget. If unnecessary services can be reduced, more funds are available to the contracting organization for distribution to participating providers. Therefore, the analytics team should review the charges for each episode to identify areas in which utilization can be affected. Since these reductions will primarily be driven by physician behavior, participation by the physician members of the team will be critical to its success.

Assessment of provider network completeness

The potential for success of a bundled payment initiative is directly related to the physician participation in managing each episode. Therefore, the MS-DRGs proposed should be those in which physicians in the related specialty are on-

board with the contracting organization, understand and agree with the objectives of the initiative, and are willing to participate in its success.

Payment amounts vs. hospital costs

The hospital may also wish to consider the internal costs and profitability of an MS-DRG in deciding whether to include it in the proposal or in determining the discount rate to be proposed. DRGs that are more profitable to a hospital may be candidates for larger discounts, while those with a lower margin may not be as attractive for discounting.

Analytical tools

The analytics team will require a robust tool set to sort through all of the data, drill down into the details, build simulation models of selected episodes at various levels of utilization, and create a comprehensive proposal for CMS that has a high probability of acceptance and successful implementation. The tools must include a back-end database that integrates the different CMS-provided files together to provide a composite view of each admission that includes all providers. Ideally that data can be integrated with the cost accounting data to provide a single view of the admission, integrating hospital costs with the provider payments. Such a system would provide a single, coordinated source of data about the admission.

SUMMARY

The Bundled Payment Initiative provides hospitals with a wide variety of opportunities to experiment with coordinated patient care that offers significant benefits to hospitals and physicians alike. Many hospitals may find this alternative to be more attractive than the "all-in" approach of accountable care organizations. ■

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Redesigning Healthcare Delivery Through Bundled Payments for Care: Q&A With Center for Medicare and Medicaid Innovation's Valinda Rutledge

By Lindsey Dunn

On Aug. 22, CMS released a request for application for the Bundled Payments for Care Improvement Initiative. The initiative, created by the Patient Protection and Affordable Care Act, incentivizes physicians and hospitals to coordinate care, which is intended to improve quality and reduce healthcare costs associated with treating Medicaid beneficiaries. For providers that are accepted, CMS will pay for an entire episode of a patient care, rather than pay for each service separately, and physicians and healthcare facilities will be able to share in any savings created by better coordinating care.

Since the details of the initiative have been released, many within the healthcare industry have applauded its fairly straight-forward requirements and flexibility; providers can apply one or more of four different bundled care models, which include both retrospective and prospective payment as well as both acute-care only, post-acute only and combined designs. As opposed to the pushback CMS received from some providers after the release of the agency's proposed rule for its Medicare Shared Savings Program, the response from providers for bundled payments seems almost glowingly positive. Valinda Rutledge, director of the Patient Care Models Group at CMS' Center for Medicare and Medicaid Innovation, discusses the rationale behind the initiative and answers key questions on how the models will work.

Q: CMS will allow providers who apply to participate in the bundled payment initiative to select from among four models. Why was it important to offer different models to providers?

Valinda Rutledge: One unique aspect of the Innovation Center is that it has the authority to identify, test, rapidly evaluate and hopefully scale models that improve the quality of care while lowering (or not increasing) the overall system cost, without having to go back to Congress. This means that we are looking for models that work in communities that are diverse in resources, population and geography. We want to make sure that what works for a large integrated health care system in Boston can also work for a small rural Oklahoma community hospital. And if there are differences that get to the same re-

sult of better care, better health and lower costs, then we need to acknowledge those differences and give providers the flexibility to improve care by the means available to them, where they are.

We want to provide a rough framework for hospitals and other providers to be able to structure their proposals. We went around the country and in listening sessions, conferences and in submissions to our "idea inbox" on our website, we heard broad consensus that innovative stakeholders most wanted us to lay out a broad framework for how they could operationalize their ideas and for us to provide enough oversight and support to protect beneficiary choice and the quality of their care, every step of the way.

Our ultimate goal for this particular program is to help support enough providers around the country in their concurrent goals of achieving three-part aim outcomes, that we can reach a critical mass of innovative healthcare leaders so that care improvement becomes the new norm. In essence, we want to remove the barriers that have historically hampered care improvement, so that every healthcare provider in this country has the means and impetus to improve the quality of care for every patient that walks through their doors.

Q: How will CMS decide which applicants are accepted into the various models; will considerations be made beyond discounts offered? Will participation be limited to a defined number of providers?

VR: In the past, it took several years to get demonstrations up and rolling. Through the Innovation Center, we have a way to test ideas, evaluate them and, if the model has been effective, potentially go to the Secretary of HHS and scale the idea [in a shorter timeframe]. If you think of [how we'll select participants] in that context, we're not going to limit it to a certain number of providers in certain markets. We first need to ensure they are great quality providers and they have protections in place for beneficiaries. [Beyond that, a key selection consideration will be] to make sure we have diversity among beneficiary participants. If we scale this — if this is something the way of the future could be based upon, [we must pilot a diverse sample].



Q: Which of the four models do you anticipate will be the most popular? Why?

VR: It's hard to say, but I envision model 1 and model 2 having the largest response. I say this because in model 1, it's the most straightforward. Because the model is around all DRGs, the applicant doesn't have to define the episode. Model 1 is focused on within the walls of a hospital, and it doesn't impact physician reimbursement [from CMS] at all. There has been some confusion around this model, but it only affects part A payments. However, we recognize that physicians have to be in the middle of redesigning care, so under model 1, hospitals can engage in gainsharing with physicians on savings for Medicare patients. The benefit of model 1 is that the barriers to care integration and improvement will be removed so that providers can focus on care redesign that has a total patient population effect, not just Medicare patients.

In model 2, hospitals, physician groups and post-acute facilities have the chance to partner with each other in ways that can get at a huge area of need for improvement: transitions between different care settings. We know that there is a huge opportunity for improvement there and that by working together, post-acute and acute-care providers can make a really positive impact on patient experience and save hundreds of mil-

lions to billions in costs through better care coordination and streamlining of care delivery.

Model 3 is interesting because it doesn't have anything to do with the hospital, it's about post-acute providers and physicians. This model was developed because post-acute providers desired a way to work with physicians to redesign care in post-acute facilities.

Q: Under the bundled payment initiative's precursor, the Acute Care Episodes project, a contracting organization was given a bundled payment from CMS to distribute to providers. The new program eliminates this requirement for models 1-3, which means hospitals no longer need the infrastructure to distribute payments as previously required. What was the rationale behind the change?

VR: With retrospective payment, the advantage is everybody — physicians, hospitals and post-acute providers — is paid their traditional fee-for-service and then there is retrospective reconciliation. Under prospective payment, CMS gives the discounted amount to one awardee and they distribute it. [Having both payment options] allows the most flexibility to providers as possible. In one community, physicians may not feel comfortable with a hospital awardee getting the payment. In another, the system might determine they can save a lot in terms of administrative costs if they accept prospective payments, so they'll choose the lump sum payments. We

want providers to think about how they can work together in their communities to redesign care and want to give them as much flexibility as possible to find the best model to meet their community's needs and fit with their traditions of working together.

Q: The new program also increases the maximum threshold for gainsharing payments to physicians to 50 percent of the fee-for-service equivalent, compared to the 25 percent maximum in the ACE project. What led to the decision to raise the limit?

VR: At the core of every decision was how to improve the quality of care for beneficiaries and ensure their freedom of choice and safety. We believed that interim lessons learned from the ACE project showed that increasing the maximum threshold for gainsharing could have a beneficial effect on the ability for physician buy-in to care improvement strategies. Also, the nature of our initiative is such that we are open to any proposal that can demonstrate why a higher gainsharing threshold may be beneficial for the success of an organization's care improvement strategy. Certainly, we will have to weigh on an application-by-application basis, the benefits and possible drawbacks of allowing for high percentages of a physician's income to be derived from gainsharing arrangements. However, keeping in mind that our first duty is to protect the quality of care and freedom of choice for Medicare beneficiaries, we wanted to be open to hearing how this policy might be used to enhance the patient experience while creating greater physician support within participating organizations.

Q: The bundled payment program is not classified as a shared savings program, meaning hospitals participating in this program can also participate in Medicare Shared Savings Program as ACOs. Do you anticipate a significant number of hospitals will participate in both?

VR: It's difficult to say. As a former hospital CEO [at CaroMont Health in Gastonia, N.C.], I think I would approach it from the perspective of what I was ready to do. The beauty of the Bundled Payments for Care Improvement Initiative is that it may be a first step for those interested in becoming an accountable care organization. For others, who are committed to becoming an ACO, the bundled payments initiative may be an important tool to start creating physician support for care improvement strategies.

Q: If you could give providers interested in applying for the program one piece of advice, what would it be?

VR: Providers should consider participating in this program, not only for the direct benefits of the program, but in the context of the changing healthcare environment. This is a strategic investment to develop the processes and competencies, local and national relationships with innovative providers, and culture to succeed in a future which will increasingly demand value over volume.

I hope that providers see this as an opportunity to either continue partnering or begin a partnership with CMS towards care redesign to achieve three part aim outcomes. The CMS Innovation Center is a great way for providers to engage the process of care improvement, and I hope the bundled payment initiative becomes the catalyst for a continued relationship towards our shared goal of making our healthcare system the best in the world.

Q: The request for applications includes application deadlines, but it doesn't include go-live dates for the pilots. When does CMS expect the bundled care payment models to be fully implemented?

VR: We'd really like to get model 1 up and running in the first quarter of 2012. Models 2-3 will be later on that year. It depends on the number of applicants we get and how much lead time they need to get up and running before implementation. ■

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7 Trends for Non-Profit Hospital Executive Salaries

By Bob Herman

As of late, there has been heightened scrutiny around the salaries and compensation packages of non-profit hospital executives. After a report was released on the pay packages of Cleveland-based MetroHealth System's top executives — ranking it in the top 25 percent of similarly sized health systems — county officials and board members showed concern about the high compensations. Hospital officials defended the raises, but MetroHealth also announced it plans to cut 450 jobs. Even New York Gov. Andrew Cuomo has delved into the details of pay for non-profit executives, recently creating a task force to review executive and administrator compensation at non-profits that receive taxpayer support from the state. “There’s always been fire around executive compensation at non-profit hospitals,” says Kathy Hastings, managing director at SullivanCotter and Associates. “Special executive benefits and perquisites, such as dependent tuition reimbursement and housing, get a lot of criticism and may in fact deserve that kind of criticism. With healthcare reform and with states struggling with their budgets and Medicaid funding, you’re going to see a lot of scrutiny around executive compensation.” With that in mind, here are seven trends she has seen evolving with non-profit hospital executive compensation.

1. Base salary increases hovering around 3 to 4 percent on average. A 3 to 4 percent increase in base salary is in line with market prices and projections, Ms. Hastings says. Salary increases for executives typically will not jump out of this range unless the hospital drastically outperforms its performance projections or if there is a hiring battle to try to recruit or retain a highly sought-after executive. Most non-profit organizations are providing some sort of increase this year because a lot did not provide increases last year due to economic uncertainty, she says.

2. Executive salary increases generally coincide with salary increases for all.

With hospital layoffs growing and hospital budgets shrinking, Ms. Hastings says a raise for executives may not occur unless all employees get an across-the-board raise as well. “That’s just a social justice issue,” she says. There have been a few examples as of late, however, involving public outcry of executive raises at the expense of stagnant or decreasing rank-and-file employee compensation. Executives at non-profit Lifespan in Providence, R.I., received raises last year, and that caused criticism from the Rhode Island Hospital Union, which voiced anger at the increases as Lifespan announced it was cutting the matching contributions to the employee’s 403(b) Fidelity plans for 2011 and will be eliminating the matching contribution for 2012.

3. Disclosures lead to competitive pay packages. All non-profit 501(c)(3) healthcare organizations fill out Form 990s to the federal government, which disclose all financial information, including executive compensation. Ms. Hastings says these disclosures are important for transparency and reviewing executive pay. The ability to compare and contrast what others are making based on the fully disclosed information sets the market rates. “Some [hospitals] are billion-dollar corporations, and you have to be able to pay for talent that can run these types of enterprises,” Ms. Hastings says. “A for-profit company is able to offer stock and company ownership to executives, but non-profit hospitals — they don’t have that type of vehicle.”

4. Incentive programs include yearly and more often long-term objectives. Most non-profit hospitals have some type of annual incentive program for its executives, and incentives hinge on several different factors, such as financial, quality, patient satisfaction and community benefit goals. However, healthcare reform is forcing hospitals and health systems to adapt toward more accountable care, and this is leading to longer-term objectives in executive compensation

incentive programs, Ms. Hastings says. Long-term objectives include integrating hospital services, amplifying physician alignment and improving patient satisfaction and quality core measures.

5. Board of directors becoming more involved in how executive compensation is set. Ultimately, it is up to the non-profit hospital’s board of directors on how much to pay the top executives, and they are taking the role a lot more seriously, Ms. Hastings says. They are looking at Form 990s and collecting competitive market data because they want their decision to be based on all available research. “They are responsible, and they are the ones that have to respond when the media calls,” Ms. Hastings says. “All of this information is public, and they have to take their job seriously.”

6. Transparency is greater. Ms. Hastings says setting executive pay at non-profit hospitals is much more transparent than five or 10 years ago. The public and government have insisted on more accountability from all types of non-profit and for-profit institutions, a result of the economic downturn. “If you look at what happened on Wall Street [during the financial crisis], the public now demands that kind of transparency, and the government does, as well,” Ms. Hastings adds.

7. Changes in compensation may also reflect an active merger and acquisition market. Non-profit hospitals have stayed active in the M&A market, and several hospital and health system executives find themselves managing more operations. Some hospital CFOs used to run one hospital’s finances, but after acquisitions, they might be operating five, Ms. Hastings says. Corporate offices are growing, and several executive positions are more complex because there is more to manage. These developments certainly are affecting how much they are getting paid, she says. ■

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7 Reasons Hospitals Struggle to Align With Physicians

By Rachel Fields

Physician-hospital alignment is becoming more important as hospitals seek to lower costs, improve care and prepare themselves for payment models that reward collaboration. Kenneth Cohn, MD, MBA, FACS, a practicing surgeon and the author of *Getting It Done*, discusses seven problems that plague physician alignment attempts — and how hospitals can achieve integration in spite of them.

1. Physicians are trained to be individualists. Dr. Cohn says while collaboration is essential to the next wave of payment models in healthcare — bundled payments and ACOs, to name a few — hospitals may struggle to align with individualistic physicians. “I think the most glaring reason it’s so difficult to align is the way we’re all trained,” he says. “Physicians have very different backgrounds and training and experience, and we tend to personalize our differences.”

During his research, Dr. Cohn interviewed MBAs and physicians and asked them what percentage of their grade during training was based on team projects. The MBAs said 30-50 percent; the physicians said zero. “I don’t think physicians in my generation ever had any formal lessons in communication or negotiation,” he says. “When I talk about win-win negotiation with physicians, they say, ‘If I have to give something up, the hospital should have to give something up, too.’” This combative attitude makes it difficult to involve physicians in hospital projects that require compromise or cooperation.

2. Employment may not be enough to spur engagement. Many hospitals are looking to physician employment to solve their alignment woes. Once they physicians are on the hospital payroll, administrators may believe they will readily engage in strategic initiatives and cost-cutting measures. But engagement may not follow employment quite that easily, Dr. Cohn says. “Physicians are a bit like tenured professors,” he says. “I’ve heard a number of deans say that just because you pay somebody doesn’t mean they put you at the top of their list.”

In the era of healthcare reform, physicians are forced to juggle the needs of their physician colleagues, hospital administrators, patients and support staff. Employment may help hospital administration climb that priority list, but it is not enough to guarantee long-term engagement with operational planning. Physicians must actually care about hospital goals and projects to participate in them. This means involving physicians in a shared vision and meaningful work that makes a difference to patients and fami-

lies — the number one priority of physicians, according to a survey conducted by Dr. Brian Wong and reported in *Future Scan* in 2009.

3. Physicians come to meetings as figureheads, not participants. Dr. Cohn says physicians often see meetings as a waste of time, a burden that cuts into their clinical duties. “You hear doctors talk about committees as a group of brain-dead people who take minutes and rob hours,” he says. “Physicians say, ‘They take me away from my office, and I’m not getting paid for it.’”

He blames this disillusionment on the fact that physicians are often brought to meetings to give their blessing on a decision rather than to provide input. “It’s very important to invite doctors to meetings before a decision is made,” he says. “In some places, physicians work in dyads together with a service-line administrator. In some places, the meetings use triads and include nurses in operational decisions.” If physicians can work on problems with their administrative, physician and nurse colleagues, they will know they have a real impact on clinical operations, rather than acting as a “yes man” for hospital administration.

4. Physicians and administrators treat problem-solving differently. Physicians are trained to take a large amount of data and distill it into a single diagnosis, Dr. Cohn says. This problem-solving takes the shape of a V: a wide amount of information coming to a point. Many hospital administrators, on the other hand, are taught to take data and use it to create different options — a style of problem-solving that looks more like a W. “To a busy physician, the administrator will look like he can’t make a decision,” Dr. Cohn says. If physicians are looking for a single solution and administrators are looking for multiple options, meetings and problem-solving may be a struggle. Start the process by talking about each committee member’s goals and thought process. The discussion may stop participants from confusing different viewpoints with malicious motivations.

5. Definition of “long-term” varies. When Dr. Cohn asks physicians to define “long-term,” the most common response is, “Forty-eight hours.” For an administrator designing a new cancer center for the hospital, this viewpoint can be a challenge. Dr. Cohn recommends that hospital administrators use “chunking” to provide physicians with a 2-3 week roadmap of outcome measures for long-term projects.

“When we check these boxes off, all of a sudden, there’s transparency, which can help build trust,” Dr. Cohn says. “After a few months, you can look

back and see how many boxes you’ve checked off.” He says this documentation will help physicians understand that long-term projects are made up of many small, essential steps, rather than just hours of deliberating and wasting time.

6. Hospitals may not make expectations clear up-front. Dr. Cohn says some hospitals have started asking employed physicians to sign a compact when they join the facility. Mayo Clinic in Rochester, Minn., has a salary, incentive, and a physician-physician mentoring system that makes expectations clear from day one; Virginia Mason in Seattle and Gundersen Lutheran in La Cross, Wis., both use compacts that prescribe certain expectations of the hospital and the physician.

“They say, ‘Read this compact over before you apply, and if you don’t agree with it, chances are you’ll be happier somewhere else,’” he says. Dr. Cohn has seen physician compacts do wonders for hospital-physician alignment and facility reputation; a few years after Wisconsin’s Wheaton Franciscan Health Care implemented a compact, the system’s main hospital joined the ranks of Thomson Reuters’ Top 100. A compact can attract physicians who want to develop a shared vision with the hospital and dissuade physicians who do not, Dr. Cohn says.

7. Physician mentors are under-utilized. According to a survey on physician turnover by AMGA and Cejka Search, 74 percent of physician groups said they believed a mentorship program reduces turnover — yet only 56 percent of groups assigned a mentor. The same is true in hospitals, Dr. Cohn says. Physicians with mentors are more likely to engage in hospital initiatives, communicate well with administrators and stay with the hospital for a longer period of time.

Physician colleagues can be great mentors because “most physicians are suspicious of top-down edicts,” he says. “You won’t see the same thing at a hospital that you would at a company like GE, where a dynamic CEO changes the culture [single-handedly].” As Dr. Cohn wrote in the July 2009 *Journal of Healthcare Management*, when hospitals assign physician leaders to mentor new physicians, physician retention soars. ■

Dr. Cohn has written several books on collaboration in healthcare. His latest, Getting It Done: Experienced Healthcare Leaders Reveal Field-Testing Strategies for Clinical and Financial Success, is available at <http://gettingitdonebook.com>.

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4 Best Practices for Supporting Employed Physicians' Independence

By Sabrina Rodak

Physicians in private practice are accustomed to having a great deal of independence in their work. This independence comes at a cost, however; they are responsible for running the practice, which may take time away from their patients. For physicians looking for a relief from business management and a greater focus on patient care, hospital employment may be an attractive option. But, physicians should not have to completely sacrifice their independence for this benefit. Having complete control over employed physicians can reduce physician satisfaction and subsequently reduce their productivity, the quality of care and patient satisfaction, the opposite of physician integration goals. However, hospital executives can strike a balance between granting some independence to employed physicians and fostering a team mentality by adhering to the following best practices.

1. Build a partnership. “Successful health systems recognize that physicians are not merely employees, but rather partners in obtaining the system’s long-term objectives,” says Katrina Slavey, network executive at Halley Consulting Group. While the term “employee” may appropriately reflect compensation arrangements, it should not necessarily dictate how the hospital treats physicians they hire.

“Physicians seek employment for a number of reasons, but they are, generally, educated and professionally socialized with an expectation of a high degree of professional autonomy,” says Bryan Warren, manager of Select International’s Healthcare Solutions division. “So, while they may in fact be an employee, they don’t always think of themselves as a traditional employee. Accordingly, providing them with some level of control over their situation and a sense of autonomy will improve career satisfaction and retention. If you can engage them in a meaningful way, you are far more likely to see higher levels of efficiency, productivity and patient outcomes.”

Part of the mission of every hospital is to deliver quality care for patients, and physicians’ main role is to care for patients. The hospital cannot fulfill its mission without the input and engagement of care providers. “Working with doctors side by side in meeting the healthcare needs of the marketplace both in the hospital and in the field are critical to the success of any healthcare delivery system,” says John R. Thomas, CEO of MedSynergies. To create a partnership between employed physicians and hospital executives, each group has to trust the other. “Building trust takes time, and that trust relationship is the key to hospitals and physicians working together today and in the future,” Mr. Thomas says.

2. Align goals. A partnership will not achieve the goals of care, however, if the partners do not understand each other’s goals. “If you’re a hospital CEO, you better have a good appreciation of the clinical delivery of healthcare. At the same time, if you’re a physician, you have to understand the business of healthcare, says Mike Soisson, senior vice president of Pinstripe Healthcare. Respecting physicians’ expertise and considering their perspective may help physicians feel that they still have autonomy as employed physicians.

Hospital leaders and physicians should communicate effectively so they can focus their efforts on clearly articulated, shared objectives. “Align goals and understand what the physicians’ expectations are,” Mr. Warren says.

In addition to identifying common goals, physicians and hospitals need to understand their role in achieving these goals. “Educating physicians who have been in the private sector and/or recently employed by the hospital system is imperative,” says Ms. Slavey. “Primary care physicians must understand their value in maintaining market share for the system. For every

dollar generated, the system can then reinvest those dollars in capital to acquire equipment that will enhance existing service lines, therefore ensuring that patient needs are met.” Helping physicians understand their role in achieving goals and providing them with the tools they need may give physicians a sense of independence and control in their work that will likely be reflected in their productivity, satisfaction and patient care.

3. Establish shared governance. Involving physicians in hospital governance may be one of the most challenging, but also one of the most effective, strategies in achieving a balance between physicians’ independence and cooperation in a team. “Many hospital leaders gravitate toward the employment model because they see it as eliminating physician autonomy and providing the hospital greater control over the medical staff, so it is difficult for these hospital leaders to then create collaborative leadership models that meet the physicians’ desire for some control over [their] situation and career,” Mr. Warren says.

From this perspective, hospital leaders’ possible reticence in granting physicians some independence may be rooted in a fear that their own independence and power will necessarily be reduced. “The practice of medicine requires a lot of self-assurance and independent decision making. It’s not easy for that type of person, whether a physician or [not], to then be a team player or not be in charge all the time,” Mr. Soisson says. “Quite often, the same thing can be said for CEOs; they are used to being in charge as well.” Successful integration and positive outcomes, however, can only be achieved if hospital executives are willing to share control of parts of hospital operations. There are several models that hospital executives can use that can give physicians some control without sacrificing their role as employer.

“We utilize a Governance Council process that ensures physicians have a seat at the table,” Ms. Slavey says. “Among other things, the council is responsible for holding the network executive accountable, developing physician compensation and contract models, system demand chain management, physician and advanced level practitioner employment and developing system-wide policy. While the CEO has a seat at the table, the council is chaired by a physician, operating under a model of being partnership-led versus physician-led. This means hospital administration and physicians work together to ensure the goals of both the physicians and the hospital are being met.” In this model, physicians are granted some autonomy while the hospital remains a key player in decision-making.

Mr. Soisson says many hospitals and health systems offer physicians leadership roles in working committees, such as those for quality management and patient safety. Physician leadership in the hospital’s finances may be particularly important. “Physicians should be on your finance committee,” he says. “As with any partnership, the more transparent the information, the better (and more informed) the decisions will be. This is particularly important in financial decisions. Don’t underestimate your physicians’ ability to understand the financial implications of the clinical decisions that they make.” Understanding the financial situation of the hospital can help physicians understand the reason for certain policies and their role in maintaining the hospital’s financial viability.

Another option for employed physicians’ leadership positions is including physicians on the board of directors. In an effort to ensure physicians’ engagement in hospital governance, some hospitals have set goals of having physicians account for fifty percent of board members, according to Mr. Soisson. Although it is important for physicians to be given some power



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and control through leadership positions, not every physician has the ability to or should hold such a position at the hospital. “Do your homework on the qualifications of the board member [candidate],” Mr. Soisson says. “Just because [he or she] is a great physician doesn’t necessarily make [him or her] a really good board member.” He suggests establishing criteria for board members that exclude their clinical specialty. For example, hospitals may identify certain leadership and communication skills as necessary qualities of a physician board member.

4. Make physicians’ role part of hospital culture. Hospital leaders can also help physicians feel a sense of autonomy by creating a culture that respects physicians as partners in the hospital and encourages physician engagement in hospital operations. As hospitals offer leadership positions to physicians, communicate with them often and solicit their opinion, over time they will create a culture that allows physicians to feel independent. Hospitals have a responsibility not only to help create a culture for physicians to thrive in, but also to hire physicians that are compatible with

the hospital’s existing or desired culture. “Perform a better analysis of the degree of ‘fit’ between the physician and the hospital,” Mr. Warren says.

“As you get more successful at [these] things, you get momentum and it starts to escalate and become the culture,” Mr. Soisson says. To test whether hospital leaders’ efforts are effective in making physicians feel that they have some control, Mr. Soisson suggests conducting surveys that ask questions such as “How much do you feel that your input is listened to and utilized?”

Achieving a suitable balance between independence and team mentality in physicians should become apparent in productivity, satisfaction and other outcome measures. “When we worked with [a] North Texas health system, we saw enhanced reimbursements, reduced subsidies and increased collections, which gave the entire group evidence that physicians were working towards the overall mission,” Mr. Thomas says. “Too much independence would have eclipsed the mission, while too much control would have demoralized physicians, hurting practice performance.” ■

Hospitals Acquiring Physician Practices: 9 Recent Transactions

By Molly Gamble

The following nine transactions are presented beginning with the most recent.

1. UPMC Acquires Erie Physicians Network. UPMC purchased Erie (Pa.) Physicians Network, which includes 10 medical offices and three urgent care centers. Effective Nov. 1, the physician group will become known as Erie Physicians Network – UPMC. UPMC officials would not disclose the terms of the sale. While a majority of the group’s 33 physicians have signed contracts with UPMC, 14 have signed to provide care through Saint Vincent Health Center in Erie.

2. WakeMed Health Acquires Urgent Care Center, Primary Care Practice in N.C. Raleigh, N.C.-based WakeMed Health and Hospitals acquired an urgent care practice and primary care practice in its local market. Effective Oct. 1, Accent Urgent Care will become part of the WakeMed Physician Practices network. The practice has two locations in Raleigh and Cary, N.C., and more than a dozen providers. Effective Nov. 1, North Wake Internal Medicine in Raleigh and its three physicians will become part of WakeMed as well.

3. Carilion Clinic to Acquire Cardiology Associates of Virginia. Roanoke, Va.-based Carilion Clinic will acquire Cardiology Associates of Virginia. The four physicians in the group will be employed by the health system. Financial terms of the deal were not disclosed.

4. Duke University Health Acquires Surgical Practice. Durham, N.C.-based Duke University Health System acquired Tolnitch Surgical Associates, a private surgical practice focused on breast cancer and disease. The three-surgeon group will merge with Duke’s Private Diagnostic Clinic on Oct. 1. The financial terms of the agreement were not disclosed.

5. Tennessee’s Methodist Le Bonheur Healthcare Acquires Internal Medicine Practice. Methodist Le Bonheur Healthcare in Memphis, Tenn., acquired Midtown Internal Medicine, also in Memphis. The practice will move from its location into the Methodist medical office building and open Oct. 12. After this acquisition, Methodist will have nine affiliated physician practices in its Foundation Medical Group.

6. Cardiology Consultants Joins Florida’s Baptist Health Care. The cardiovascular group Cardiology Consultants has joined Pensacola, Fla.-based Baptist Health Care. Cardiology Consultants affiliated with Baptist Health Care in 2010 and is now aligning fully to build a regional heart and vascular program. It will establish its main office location at Baptist Hospital in Pensacola and provide office visits, diagnostic care and treatments at all four BHC hospitals and its two medical parks.

7. UnitedHealth Group Buys 2,300-Physician Practice in California. UnitedHealth Group will acquire 2,300 physicians through its purchase of Monarch Healthcare, the largest medical group in California’s Orange County. UnitedHealth’s business platform Optum will take control of Monarch’s management. Optum, which is separate from UnitedHealth’s insurance operation, also controls the management of two other California physician groups: AppleCare Medical Group and Memorial HealthCare Independent Practice Association.

8. St. Joseph’s Health Acquires Two Vascular Practices in Atlanta. St. Joseph’s Health System in Atlanta acquired two vascular practices, adding seven physicians to its staff. The system has purchased Georgia Vascular Clinic and The Vascular Institute of Georgia, both located in Atlanta. Financial details of the acquisitions were not disclosed.

9. New York’s White Plains Hospital Acquires 9-Physician Practice. White Plains Hospital in Westchester, N.Y., recently acquired White Plains Surgical Specialists, a nine-physician practice. The practice will join White Plains Hospital Physician Associates, which is now comprised of three physician practices: the surgical specialists group, a two-physician obstetrics practice and a three-surgeon orthopedics group. ■

Survey: 65% of Employers Interested in ACO Model

By Lindsey Dunn

A recent survey by Aon Hewitt and Polakoff Boland found that 65 percent of employers are very interested, interested or somewhat interested in exploring the use of an accountable care organization to improve quality and reduce cost of employer-sponsored health benefits, according to a news release.

The survey of 675 U.S. employers revealed 28 percent of employers are interested or very interested in exploring ACOs, while 37 percent are somewhat interested, 24 percent are unsure and 11 percent are not at all interested. Quality of care delivered is the top ranked factor by 82 percent of employers in evaluating the use of ACOs. This was followed by the ability to manage the total cost of care (81 percent), patient outcomes (66 percent) and plan/provider pricing transparency (47 percent).

Nearly 80 percent of respondents said awareness or reputation of the sponsoring organization is critical or important in influencing employees in a positive manner, and 71 percent of organizations said having different ACO networks or models to choose from would be a critical or important positive influence on workers. ■

Only 9 Percent of Physicians Feel Ready for “Business Side” of Medicine

By Molly Gamble

Medical residents are feeling the pull of hospitals and medical groups, as 78 percent of residents said they have been contacted by recruiters more than 51 times during their residency training, according to a survey conducted by Merritt Hawkins.

The *2011 Survey of Final-Year Medical Residents* reflects generally positive attitudes toward hospital employment, as 32 percent indicated they would prefer to be employed by a hospital more than any other option. Only one percent of residents said they would prefer a solo setting as their first practice.

Only nine percent of residents said they're prepared for the business side of medicine, and 56 percent of residents said they did not receive any formal instruction on contracts, compensation arrangements and reimbursement models during medical training.

Also, the survey found that 72 percent of residents expect to make at least \$176,000 or more in their first practice. ■



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Study Finds Weak Correlation Between Financial Incentives, Improved Quality of Care

By Molly Gamble

A recent study found “little rigorous evidence” linking financial incentives to improvements in quality of primary healthcare, and little proof that such an approach is cost-effective compared to other quality improvement initiatives.

In the study, “The Effect of Financial Incentives on the Quality of Health Care Provided by Primary Care Physicians,” the Australian authors based their review on seven studies of incentive programs in the United States, United Kingdom and Germany. Three studies evaluated single-

threshold target payments, one examined a fixed fee per patient achieving a specified outcome, one evaluated payments based on the relative ranking of medical groups’ performance (or tournament-based pay), one examined a mix of tournament-based pay and threshold payments and one evaluated changing from a blended payments scheme to salaried payment.

The authors examined how physicians under these payment plans screened for diseases, referred patients to follow-up care or helped patients achieve a certain outcome. The results

were mixed. Six of the seven studies showed positive but modest effects on quality of care for some primary outcome measures, but not all, according to the study.

The authors concluded that more rigorous study designs need to be used to account for the selection of physicians into incentive schemes, and implementation of financial incentives should proceed with caution. The authors also suggest incentive schemes be more carefully designed before implementation. ■

NEJM Analysis of Physician Group Practice Demo Results Questions ACOs’ Success

By Molly Gamble

A report published in the *New England Journal of Medicine* suggests that results of CMS’ Physician Group Practice Demonstration may not have been as successful as presented.

The report, authored by Gail Wilensky, PhD, points out that only two of the 10 participants were able to exceed a 2 percent savings threshold in the first year of the five-year demonstration. Furthermore, only half managed to surpass the threshold after three years. These findings are important due to what they suggest about accountable care organizations’ likelihood of success, according to the report.

The PGPs also suggested that some of the challenges were rooted in design issues, such as the way comparator groups were constructed or how patients were attributed to PGPs. Furthermore, most of the PGPs were in low-cost areas, which made it more challenging to find savings than it may be for ACOs in high-cost areas, according to the report.

In the report, however, Dr. Wilensky does applaud the PGPs’ performance on quality metrics. By the fifth year, seven groups achieved benchmark-level performance on all 32 measures, and the remaining groups did so on at least 30 measures. ■

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Physicians Fight to Keep the Word “Doctor” to Themselves

By Molly Gamble

Many physicians are worried about “doctor” losing its traditional definition as more nurses, pharmacists and physical therapists earn doctorate degrees, and some physicians are taking their resistance to the legislative level, according to a *New York Times* report.

A bill proposed in the New York Senate would prohibit nurses from calling themselves doctors despite their degree. Laws already in place in Arizona, Delaware and other states forbid nurses, pharmacists and others to use “doctor” in their title unless they “immediately identify their profession,” according to the report.

While “collaborative care” has become a mantra of healthcare reform, not all physicians are willing to give up the traditional idea that they direct a patient’s care. Some are concerned the increased usage of “doctor” will confuse patients, while the report says a deeper battle is over who gets to treat patients first.

Another facet of the debate is that increased use of “doctor” may muddle understanding of a provider’s training. Pharmacists, physical therapists and nurses can earn doctorate degrees with six to eight years of collegiate and graduate education, according to the report, while it takes nearly twice that many years of training for most physicians. ■

42% of Primary Care Physicians Say Their Patients Receive Too Much Care

By Molly Gamble

More than 40 percent of primary care physicians in the United States think their patients are receiving too much care, and 76 percent of those respondents said malpractice concerns played a role, according to a new report from the *Archives of Internal Medicine*.

Along with malpractice risks, physicians also cited clinical performance measures, inadequate time with patients and financial incentives for aggressive practice. For instance, 62 percent of physicians said diagnostic testing would be reduced if it did not generate revenue for medical subspecialists.

Physicians also expressed inconsistency in their delivery of care: Ninety-five percent believe physicians vary in what care they would provide for identical patients.

More than 75 percent of physicians expressed interest in learning how aggressive their practice style is compared to that of other physicians in their community, which suggests they may be receptive to change, according to the report. ■

Physicians Focus on Various Factors When Referring to Colleagues

By Molly Gamble

Primary care physicians and specialists have different reasons for referring patients to certain colleagues, according to a new study published in the *Journal of General Internal Medicine*.

Michael L. Barnett, MD, from Harvard Medical School in Boston, and colleagues investigated why PCPs and specialists choose specific col-

leagues for referrals and how these reasons differ according to specialty. According to their findings, PCPs and medical and surgical specialists initiated referrals to 66, 49 and 52 percent of their professional-network colleagues, respectively.

Medical specialists were less likely than PCPs to report ease of communication with colleagues.

Both medical and surgical specialists were less likely to report shared electronic medical record systems as a reason for their referral.

The study concluded that specialists frequently initiate referrals, but not so much PCPs. When choosing which physicians to refer to, PCPs are more focused on between-physician communication and patient access. ■

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Calling It Off: Why Some Hospital Mergers Fail and Others Don't

By Molly Gamble

Each week, more hospitals announce plans to merge, combine or express interest in some type of partnership arrangement. While many of these deals are executed successfully, another outcome is also possible — that of the transaction unraveling.

In the past year, nearly 25 percent of announced letters of intent failed, according to some estimates. A letter of intent is a non-binding agreement in which parties establish the principal business terms and, in most cases, announce transaction plans to the public. *[Editor's note: For the sake of clarity, this article pertains to transactions that are not completed after parties signed an LOI.]*

A merger might fall through for a handful of reasons. A lag in timing may slowly kill it. Parties might learn something negative about one another later in the discovery process — a finding that was not initially recognizable on paper but becomes jarringly apparent weeks after the letter of intent. The hospital may have rushed in its marriage to one partner without seeking other bids. Hospital employees, physicians or community members may think the transaction was orchestrated in a questionable or closed-door manner, which creates an enormous amount of backlash.

Any one of these issues, and many more, can derail a merger. Here, experts discuss the reasons hospital transactions can go awry, best practices to avoid problems, and possible serious negative repercussions hospitals and leaders face if a deal does fall through.

Time kills deals

Bart Walker, JD, uses three simple words to sum up a significant concept when it comes to hospital transactions: “Time kills deals.” Mr. Walker, an attorney with the healthcare practice of McGuireWoods in Charlotte, N.C., says a slow-moving deal can potentially unravel itself. “The longer anything lingers, the greater a chance that something will go wrong,” he says.

This is usually an issue created by the seller, but the burden is shifted to the buyer when something unfavorable is discovered. “Sometimes big issues come up that weren't on anybody's radar,” says Mr. Walker. This can be a financial issue, such as something related to taxes, or litigation. Parties usually attempt to salvage the relationship, which may or may not be successful. “There are transactions that die and come back to life multiple times before they're finally executed,” says Mr. Walker. “Others die and never come back.”

The effects of a lagging transaction can trickle down to the seller's hospital employees, as uncertainty may feed their concerns about layoffs or undesirable working conditions. It could also drive patients away from the hospital, since patients might think the hospital is in transaction limbo and go elsewhere for care. Combined, these repercussions can lower the hospital's value.

Bo Hinton, managing director with Coker Capital Advisors based in Atlanta and Charlotte, N.C., has firsthand experience with a transaction that fell through. In a period of four months, the seller's earnings declined due to a myriad of reasons, including economic conditions, issues with medical staff, and stakeholders' concerns around the merger itself. In the end, a valuation gap resulted in a deal unable to close.

“The seller can remember that, only a few months ago, their earnings were relatively high. But the buyer is uncomfortable, and has no reason to believe that this isn't the new normal for that hospital,” says Mr. Hinton. He says variations in earnings — from early discussions when the initial price

is determined compared to the price when deals are about to close — are a large factor in failing transactions.

No transparency, no transaction

A transaction structured without accountability and straightforward communication faces only a small chance of smooth success. It varies among marketplaces, but the voices of physicians and community members can be extremely powerful when it comes to support for mergers and acquisitions. Whether intentional or not, it's unlikely that the public will support a deal they consider underhanded.

“In smaller or mid-size areas, the hospital may be the largest employer in the community. It might be owned by the county. So, as a result, there can be much more emotion tied up in that transaction process and the significance it has to the local community,” says Mr. Hinton.

While transparency is ideal, ignorance of fiduciary duty, conflicts of interest or rushed timing can all lead to questionable transparency. This can lead to extensive problems if not the entire collapse of a deal. Recently, Warren Hospital in Phillipsburg, N.J., received a large amount of backlash from physicians who claimed they were left in the dark when the hospital decided to merge with St. Luke's Hospital and Health System in Bethlehem, Pa. More than 50 physicians publicly criticized the hospital's board via newspaper ad after it formed an exclusive agreement to sell to St. Luke's while rejecting an offer from Community Health Systems the same day it was received.

Besides being bad practice, questionable transparency can also be illegal. All states have their respective open records and open meetings laws. Florida, for instance, has a Sunshine Law that protects the public from closed-door decision-making by a board on any state agency, or authorities of county or municipal bodies. Southeast Volusia Hospital District violated this law in 2010 when it sold Bert Fish Medical Center in New Smyrna Beach, Fla., to Adventist Health after holding 21 private meetings. In February, a judge ordered the sale (which had already been completed) to be undone as a result of the misconduct.

Faulty transaction design

A deal is more likely to go awry when hospital boards or executives enter discussions with a partner without a well-defined idea of what the transaction should entail. What sounds appealing to both parties over informal meetings may not seem as attractive when written in a definitive agreement's contract language, and the deal could fall through due to gaps in expectations. The economic gaps are often measured in the tens of millions of dollars.

Jordan Shield, a vice president at Juniper Advisory in Chicago, says there are two types of LOIs: soft and detailed. Soft LOIs are developed and signed before the deal's terms are defined, which are “asking for trouble,” according to Mr. Shields. Instead, hospitals should develop detailed LOIs, which lay out the specific terms of the transaction.

Recently, more LOIs have been released to the public, announcing mutual interest in affiliation. These are often followed by “research” into each organization and its financial issues, such as capital expenditure needs, and structural details of the transaction are revealed in the definitive agreement. This sequence is out of order, according to Rex Burgdorfer, a vice president with Juniper Advisory.

Discovery and research should occur before signing an LOI. This will determine whether or not the parties are serious and on what terms, and should be completed well before a public announcement. The LOI should outline clear, mutually-agreed upon principles of the deal. The period between an LOI and a definitive agreement should confirm the information each party shared in that discovery process. Finally, definitive agreements should then document the understanding parties outlined at the LOI stage.

Bilateral discussions destroy value

“One-on-one conversations are never going to yield the best outcome from the seller’s perspective,” says Mr. Burgdorfer. “There needs to be competition.” Hospitals should go to market and collect multiple proposals so they have a range of options. “The worst thing a hospital can do is act on that [first] bid without full information of what else is out there,” says Mr. Burgdorfer.

“Oftentimes, you’ll see failures when the board has an offer and they assume the potential partner is best without fully vetting other opportunities. They sign an LOI, it goes public, and another suitor comes forward with a better offer,” says Mr. Shields. This becomes more than an issue of a hospital receiving a low-dollar bid, as it can also involve board seats, maintenance of service lines or capital commitments.

“It might be a new specialty program or a commitment to bring in new physicians,” says Mr. Shields. “I’ve never seen a situation where all of those things are maximized in a bilateral conversation. The board gets one shot at this and should not do it in a vacuum.” The original partner might prevail at the end of a competitive process, but after pressure from other participants, its offer is likely to be more comprehensive and advantageous for the seller.

Repercussions of a failed merger

There are bound to be repercussions when a deal fails to close. Greg Zoch, managing director with executive recruiting and search firm Kaye/Bassman, says both parties may suffer damaged reputations due to public misperceptions after a failed merger.

“If the deal was made public, and then not completed, it begs the question as to why,” he says. Post-transaction communication can be difficult, and both parties should coordinate how they will frame the news in a way that doesn’t harm either organization or insinuate fault or bad faith.

“Essentially, you’re talking about a break up. These two organizations were going to get married and now the wedding is off,” says Mr. Zoch. “People are going to fill in the blanks.” Savvy public relations professionals are crucial to communicate a message effectively and address public and employee concerns.

A failed merger might affect a hospital’s standing with physicians, its ability to recruit them, or its good-will in the community. It is also a financially costly process, as organizations spend a large amount of money on the diligence process. Break-up fees, to be paid by the party calling off the deal, can be built into agreements.

Hospital CEOs can also face a tarnished period in their career if they are leading a hospital through a deal that never closes. Some CEOs might even be forced to step down, depending on how closely they were tied to the transactions’ unraveling or if it was somehow a result of CEO oversight or negligence. This causal link, though often not publicly exposed, certainly remains a risk to hospital executives. ■

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The Ins and Outs of Successful Hospital Insurance Negotiations and Service Pricing

By Bob Herman

When it comes to health insurance contract negotiations, the battle between hospitals and insurers can be of heavyweight-caliber. The importance — and potential ramifications — of payor negotiations has been exemplified in the dispute between the University of Pittsburgh Medical Center and health insurer Highmark, as their contract covering roughly 3 million people could end on June 30, 2012, putting the hospital, insurer and patients at risk of an insurance debacle. Additionally, Highmark is exploring an acquisition with UPMC competitor West Penn Allegheny Health System in Pittsburgh, which has only intensified disagreements between the two parties and changed how hospitals must deal with insurers.

The health reform law is also rearing its head into the insurance discussion, as it will significantly restructure how and to whom health insurers provide coverage. By Jan. 1, 2014, under the Patient Protection and Affordable Care Act, health insurers will not be able to discriminate against or charge higher rates for any individuals based on pre-existing medical conditions, health insurance exchanges will be in full force to give people a marketplace for choosing health coverage and numerous other conditions will impact how people can receive coverage and how healthcare groups handle coverage.

Hospitals must negotiate with their payors periodically, and it might not always be an easy task. Now, with both reimbursement cuts as well as health coverage expansion, payors might be asking a lot from hospitals. There are several things a hospital can do, however, to prepare properly for insurance negotiations.

Understanding your contract and prep work

Typically, large health systems do not have problems with the pre-negotiation steps; it's usually community and regional hospitals that have a more difficult time because the people that negotiate payor contracts usually wear several different hats at the hospital and may not have all the software tools that can help model contracts, says Kyle Kobe, principal at Equation, a healthcare consulting firm.

The first and most important step to a hospital's payor contract negotiations is to do the homework and take the time to understand the existing contracts, Mr. Kobe says. Hospitals must benchmark contracts against each other, see how all of their managed care contracts compare to others and figure out the financial impacts of each contract. For example, comparing rates among Aetna, CIGNA and Blue Cross Blue Shield plans can give a hospital an idea of where rates are at in the market and how a hospital's current contract can be improved, Mr. Kobe says.

Furthermore, hospitals should do the research ahead of time to know what percentage of the insurer's business comes from the hospital. If a hospital shows a payor that it is 40 percent of the payor's business in cardiology, it builds a picture and gives the hospital leverage to show just how many patients they are serving on the payor's plan. Other numbers to have include the range and demographics of the patient population, the average cost per patient, the average cost per episode of care, costs per diagnosis code and the average cost to the payor of what they are currently reimbursing. "Tell how they affect you, but also tell how you affect them," Mr. Kobe says. "Payors will have the numbers together and know what they're talking about. You'll be at a major disadvantage if you don't take the time to compare contracts to each other."

Conducting research on current contracts goes hand-in-hand with keeping an inventory of all contracts and setting up a system that indicates which payors are coming up for a renewal, says Mary Ely, director of physician relations at Greater Baltimore Medical Center who is also in charge of managed care and negotiations with insurers. At GBMC, Ms. Ely reviews volumes, denial histories, Medicare fee schedule changes and other payor contracts prior to renewals for her research.

The mountain of information cannot deter a hospital's managed care department, though, because the research and comprehension of current contracts sets the tone for all discussions. "Sometimes it seems overwhelming when it comes to doing the homework and gathering the information you should put together," Mr. Kobe says. "But if you're planning ahead when contracts are due, there's not one hospital that can't do this."

Negotiations and the power of data

In order for negotiations to be seamless and less confusing, Mr. Kobe says it is best to space out contract negotiations throughout the year so a hospital is not negotiating everything with a majority of payors all at once. Additionally, a hospital could lose some negotiation leverage by having everything come up at once because the hospital would then be at risk on all or many contracts, which could lead to overly compromised deals.

When it comes time to sit at the negotiation table, there are several things hospitals should vie for — and a lot needs to be based on the research that was conducted beforehand as well as contract modeling software. Without clout, a hospital's bargaining power needs to come from data, Mr. Kobe says, and that data needs to show how proposed rates could help or hurt the hospital or practice.

Firstly, hospitals need to look at services where there could be opportunities for carve outs, which are contracts paid under a different arrangement. For example, if a hospital is only 20 percent of an insurer's inpatient business but 50 percent of its cardiac services, that is an area where the hospital can push and look for better reimbursements rates, Mr. Kobe says.

Highlighting the quality aspects of a program, the credentials of physicians and other areas that add value shows the hospital does not want an arbitrary rate increase — it shows the hospital is taking things seriously, Ms. Ely says. She adds that clear communication between the hospital and payor is essential, especially if the contract language needs to be renegotiated. For instance, Ms. Ely says any questionable or vague clauses that involve legalities or payment procedures like appeals processes should be scrutinized so disputes later do not cost the hospital money.

Finally, hospitals want to routinely update evergreen contracts, which are contracts that have much longer terms. Mr. Kobe says hospitals want to look at renegotiating contracts every two to three years, and evergreen contracts especially need updating because those types of contracts typically collect dust if no one is paying attention. "Nothing will happen unless someone raises their hand and says there needs to be a change," he says. He adds that hospitals should look to put "risers" in those types of contracts. Risers are stipulated increases over the life of a contract. For example, if a hospital negotiates a three-year contract with a payor, there could be an automatic 2 percent increase, or riser, after the first and second years to adjust for inflation.

Competitive pricing

Comparing payors against each other and knowing the hospital's market shares in all services are essential tools for negotiations, but hospitals also need to pay attention to the rates of other nearby hospitals, says Brian Workinger, business solutions consultant at Craneware. A hospital cannot price itself out of the market because it could eventually lead to weaker payor contracts and, ultimately, lost patients. "A competing nearby hospital may be 20 percent as much for the same procedure, and in the consumer-driven healthcare we're in now, the patient can go down the street and possibly save a substantial amount of dollars," Mr. Workinger says.

Prices for a hospital's procedures and services must be in line with other facilities in close proximity for the sake of not losing patients, but they must also match payor contracts. Payor payment that is inconsistent with contracts creates headaches for insurers and could stall future negotiations. Additionally, if hospitals do not take active steps to ensure payment matches contracts, they could lose out on valuable revenue. That's why a hospital's chargemaster is so important, says Kelley Blair, senior vice president of professional services at Craneware. Chargemasters show what a hospital charges for all services provided, and there are three items all hospitals need to do with chargemasters for compliant pricing and to ensure they stick to the payor contract.

1. Keep codes up-to-date. CMS updates its codes quarterly, although that schedule will be slightly altered as ICD-10 becomes standardized. Regardless, hospitals must keep their codes current because payor contracts

might differ from CMS. This could lead to confused billing and perhaps unnecessary denials.

2. Have dedicated chargemaster person/team. Ms. Blair says a dedicated chargemaster manager or team can recognize the importance of its maintenance and can identify when, for example, a BCBS plan needs to be charged differently from a UnitedHealthcare plan.

3. Be proactive and conduct complete reviews with department managers. "From a clinical person's perspective, the last thing they care about is making sure the chargemaster updated," Ms. Blair says. "They are worried about everything from patient care perspective." Therefore, those involved with the chargemaster must meet with service line department managers to see what services are being provided and if there have been any new divisions, services or updates. A proactive review is a key step in bridging the gap between the clinical and financial areas.

In the end, Michael Najera, professional services manager at Craneware, says hospitals must be compliant in its pricing with all regulatory bodies, but they must keep a more important and simple main goal in mind during these negotiations: Find the right contracts and price points that will make the hospital's services sustainable. "Ultimately, the financial objective is to ensure the revenue you're generating is sufficient to provide services to those that are in need your community but cannot afford to pay and to also ensure capital is available to reinvest in the facility to deliver recent or modern care with the latest equipment," Mr. Najera says. ■

ICD-10: Will It Kill a Hospital's Productivity?

By Bob Herman

Converting to ICD-10 can be viewed as a homework project in two different ways: Some hospitals may want to complete it early to put their minds in a state of relative ease, while other hospitals may be putting it off until the 11th hour, dreading the very thought of picking up the pencil and starting the assignment.

For hospitals in the latter of the two mindsets, time is nearly out, and ICD-10 needs to be taken seriously, says Bill Hannah, CFO of special projects at Piedmont Hospital in Atlanta. ICD-10 will be going live on Oct. 1, 2013, and he says it will completely change the way a hospital functions — and productivity will be negatively impacted at first. Mr. Hannah is leading the ICD-10 conversion at Piedmont, and he explains the extent of ICD-10's future impact on hospitals.

Challenges and impacts on productivity

ICD-10 will create many technical problems with new coding and billing procedures, but Mr. Hannah says one of the biggest obstacles for ICD-10 transitions has been getting people to understand the negative consequences if their organization is not at least somewhat prepared. "The impact that people haven't yet got their

head around is that this is not an IT problem, and it's not a medical records coding problem," Mr. Hannah says. "This is a business challenge that will make you operate differently."

Some of the direct, specific impacts will be the initial costs that a hospital will incur to get ready for ICD-10. Mr. Hannah says a lot of the costs are associated with IT applications, and almost any system of a hospital will have to deal with upgrades: billing, medical record coding, laboratories, radiology, pharmacies, emergency department systems and more. Depending on the size of the organization, these costs could be in the millions. He says large health systems could spend between \$5 million and \$10 million over the next two-and-a-half years on upgrades needed for the conversion.

After gaining staff attentiveness and fighting through the costs, Mr. Hannah says hospitals will still probably see a significant increase in accounts receivable, perhaps of two weeks or more, for the first six to 12 months while everyone catches up with the new coding, terminology and general nuances. There will also be a likely increase in claims rejections and denials from payors.

"There's going to be a new normal," Mr. Han-



nah says. "You can prepare for something like this as much as you want, but you'll never be fully prepared. You must start now, take it seriously and make sure that you have senior executive support for all of the changes and modifications that you're going to have to go through."

Communication and education

So what exactly can a hospital do to prepare for ICD-10? Mr. Hannah says every organization should attempt to instill a readiness program that communicates with and educates all employees, physicians, senior leaders and community partners on ICD-10's implications. Points that have to be clarified include the very basics, such as what ICD-10 really is, where did it come from, what does it mean, how codes will be impacted, how it will change a hospital's order of operations and more. Anyone who currently relies on ICD-9 to perform a clinical or business function needs to be re-educated, Mr. Hannah says. A hospital's future productivity depends on it. ■

9 Recommendations for Hospital Health IT Staffing and Training

By Bob Herman

While unemployment continues to saturate the nation's working classes, there has been one field within healthcare where the demand has been higher than the supply: health information technology. According to a survey by IT management firm Computer Economics, 61 percent of healthcare organizations are increasing IT staff this year, the highest rate of any sector among the organizations surveyed. Additionally, healthcare providers have grown their IT operational budgets by 3.1 percent since last year, according to Computer Economics, something several other sectors cannot say they are doing.

Martin Memorial Health Systems in Stuart, Fla., is one provider that has ramped up its health IT staffing and training efforts. Ed Collins, vice president and chief information officer of MMHS, says last year, the health system began updating its IT infrastructure in its transition to electronic health records with Epic, a health IT vendor. Situated in a market where 75 percent of its patients rely on Medicare, Mr. Collins knew MMHS had to put strong tools in place to receive the meaningful use stimulus money on time. Now, nearly one year later, he says they are ready to go live in December.

In the long term, hospitals and health systems will look to health IT to extract data to prove they are providing quality care, but in the short term, they need the personnel — both internal and external — to implement it all. Here are nine recommendations for hospital health IT staffing and training during EHR implementations.

1. Create a sense of urgency. Mr. Collins says showing the importance of these projects, specifically the EHR projects, should be displayed to vendors, hospital leadership and potential health IT staff members. After deciding last August to implement EHRs, MMHS needed a team of approximately 60 people to be staffed and trained by October to start the project. They completed the task with tight deadlines, and Mr. Collins says they actually have more than 70 positions dedicated to the project now.

Kimberly Bowden, president and CEO of 1st Solution USA, has seen the urgency firsthand. The federal government incentives were not a primary concern for all providers in 2009, but much has changed since last year. "In 2010, everyone started waking up and said, 'This deadline is coming up fast, and we might be far behind,'" she says. "The last time there was this type of urgency was Y2K. But this deadline is worse because it's affecting pocket books and [the hospitals'] reimbursements."

2. Look at internal, clinical people to own the projects. Because so much of EHR implementation involves clinical processes, clinicians should be involved in EHR system development. When MMHS began its EHR development journey, Mr. Collins approached department leaders to offer up some of their best clinical and operations employees to help guide the system. He informed them that his team would need these staff members for upwards of a year and a half, maybe longer, and there would be no guarantee they would go back to their original positions. For MMHS' project, Mr. Collins says hiring internally and working collaboratively with other departments was the best way to lay the foundation for the project's staff because they have the mindset of the people who will work with the systems the most. Teaching them the basics of IT was the smaller cliff to jump than looking for outside IT staff familiar with clinical issues. Overall, Mr. Collins says roughly 90 percent of his EHR implementation staff was hired internally.

Clinical input from multiple areas can increase the likelihood implementation will be well received by the hospital's entire workforce. "A lot of

hospitals underestimate gathering requirements on the front end of the implementation," Ms. Bowden says. "If you're shoving a new solution down [physicians' and nurses'] throats and saying, 'We're going to go live next week,' that's not going to go well."

However, most health IT projects are not exclusive to internal staffing. Recruitment must take place, and for Mr. Collins, it began within the community. The 10 percent of his EHR implementation staff that was hired externally were all local candidates. Emphasizing the appeal of working locally without the rigors of traveling associated with vendor positions is one way hospitals can look for their external help. Successful hospitals could also engage with a recruiting firm to view candidates from a specialized database, Ms. Bowden adds.

3. Have an engaged team of executive and clinical leaders.

A hospital's CIO, chief medical officer and other executive and clinical leaders must be open-minded and diligent when it comes to these types of health IT initiatives and staffing issues, Ms. Bowden says.

Mr. Collins reiterates this point, saying the dedication of his team's work ethic has powered the successful implementation. It's been especially evident as MMHS gets closer to its "go-live" date. "It can be extremely stressful," he says. "This is where the stress and pressure really builds, and it requires a different work ethic when you work in the IT space."

4. Use federally funded health IT training programs as a resource.

The Office of the National Coordinator for Health Information Technology graduates students from various community colleges throughout the country in several different health IT backgrounds. These include information management redesign specialists and implementation support specialists. Similarly, Ms. Bowden has worked with the University of Texas at Austin, which offers a nine-week extensive training course on EHRs. These resources can offer a multitude of candidates in a field of different health IT positions if hospitals are struggling to find internal candidates.

5. Temper expectations for external candidates. While there are many students going through health IT training programs, Ms. Bowden says the younger workforce is getting scooped up by the vendors because the vendors offer a more appealing work environment. She says most successful hospitals will temper expectations, realizing they won't always find external people with five years of EHR experience.

6. Inform candidates of challenges. Mass-scale health IT projects like EHR implementations are big commitments in terms of dollars spent and hours worked. Mr. Collins says the hospital held two town hall meetings to inform internal candidates they would be working hard with long hours and no overtime. Additionally, working on weekends and holidays would be commonplace, and after the project is over, there would be no guarantee they will have a job. However, he says hospitals must motivate them to take the leap of faith because it will be "the most rewarding project" they've ever worked on. "We wanted to alleviate some of their fears but also inform them to say it's serious, and you can't change your mind halfway through," Mr. Collins says.

7. Consider hiring a transformation specialist. Transformation specialists are people that specialize in these types of massive organizational changes, such as a hospital taking on new health IT projects. These specialists can also spot out areas where extra training is needed. For example, there may be nurses on the floor that have never used a computer before and need basic computer training before moving on to EHR train-

ing. “Hospitals need to realize how important it is to mentally prepare for this change,” Ms. Bowden says.

8. Motivate the team during training and beyond. Training to learn new EHR systems can create a data overload of sorts. While it may be easier for younger hires to grasp, Mr. Collins says there are many people who have been out of school for several years who are not used to the rigors of high-pressure studying and training. “There is a ton of pressure on these folks to learn this stuff in a short period of time,” he says. “You have to be able to help those last few people cross the finish line.”

9. After staff is set, make sure there is full confidence in those chosen. After Mr. Collins appointed a chief clinical information officer to manage the EHR project, the accelerated hiring process began. Within weeks, the team of applications analysts, report writers, trainers and other health IT staff members was cemented through internal and external searches. In a way, Mr. Collins says he would equate the final layout to a fantasy football draft. With the board filled out and team members placed in specific grids to do particular tasks, all of the directors must be happy with their teams to roll into the implementation. ■

12 Elements to Support a Viable Health IT and Telehealth Infrastructure

By Bob Herman

Health information technology has essentially become a requirement for all niches of healthcare — rural, urban, state, local, federal and everything in between — and it’s evident that a strong health IT infrastructure will help providers transition into the new era of stronger quality care.

The Oregon Health Network is one example of an organization that is trying to assist local providers in health IT implementation, especially within the telehealth realm. OHN received a subsidy of more than \$20 million through the Federal Communications Commission’s Rural Health Care Pilot Program, and it aims to improve the disparity and quality of care for Oregon’s geographically and economically diverse population through telehealth promotion. Kim Lamb, executive director of OHN, says hospitals and other providers are going to be instrumental in keeping these types of health IT infrastructures strong, and for hospitals’ communities to thrive in the dawn of telehealth, there are 12 key elements providers of all types and sizes, including hospitals, must address to experience the full benefits of strong health IT.

1. Strategy and vision. Ms. Lamb says health IT solutions need common goals in order to become mainstream and successful, and those goals come in the form of the “triple aim.” “If we are trying to implement the next generation of healthcare, we need to get behind the triple aim — enhanced patient experience, improved population health and cost reduction,” Ms. Lamb says. Health IT strategies must also be created with those three missions in mind, she adds.

2. Collaboration. The OHN is collaborating with healthcare providers and supporting organizations across the state on how to make Oregon more integrated and reduce the disparity of care. In order for the entire nation to become integrated, Ms. Lamb says the FCC, CMS and the Office of the National Coordinator for Health Information Technology must continue their support regarding meaningful use of electronic health records, Regional Extension Cen-

ters and other telemedicine services for hospitals and other providers. Additionally, hospitals and providers must take advantage of the resources afforded to them to support the required national momentum.

3. Connectivity. Telehealth and health IT networks do not create themselves. Ms. Lamb says statewide health networks like the OHN are like the highways of telehealth, and no one can drive anywhere unless the highways are able to support the future healthcare delivery system and are well-connected. Similarly, hospitals and providers need to have solid connections on their side if telehealth is a serious feature of their future plans. “We need to have a means to physically deliver high-speed, high-quality infrastructure that can support current and future applications,” Ms. Lamb says. “You don’t have value if you don’t have a means to connect centers of excellence and specialists to a rural community.”

4. Implementation. The physical implementation of these IT networks and supporting systems requires another set of niche expertise to select the appropriate technologies, process and outcomes to serve the primary strategy and plan. “There is implementation expertise needed for many of the health IT best practice areas,” Ms. Lamb says. “Don’t ask an electronic medical record specialist to take on your telehealth program planning and deployment efforts. Many times, they’re entirely different experience and skill sets.”

5. Information. Hospitals must remember that EHRs are not the sole component of the nation’s broad health IT framework. They are just part of solution that focuses on delivering correct information to patients, which leads to higher quality care. “Health IT is not about electronic medical records; it’s about getting the right information to the right person at the right time,” Ms. Lamb says.

6. Support. Hospitals never take a break for patient care, and now the same will be required of broadband connections and other mediums for telehealth. Ms. Lamb says that broadband con-

nections, as well as all the programs and services that run on them, must be maintained at all hours of the day as well at both ends, which will require more resources and potentially more staff.

7. Measurement. To make sure hospitals, providers and health IT organizations are adhering to the “triple aim,” Ms. Lamb says they should measure certain metrics and compare them to those goals. These metrics should show whether health IT efforts have been successful, such as EHR data improving population health or telemedicine data showing cost savings.

8. Education. Technology is an area that not only improves frequently — it strives to improve frequently. Hospitals that interact with telehealth must engage all users involved to be up-to-date on all technological components. Ms. Lamb suggests in-person trainings and other hands-on materials because everyone from staff members to the patient community absorbs information differently.

9. Recruitment and retention. The demand for health IT professionals has risen exponentially in the past few years. Hospitals must be able to meet the demand through strategic health IT staffing and training, she says.

10. Credentialing and privileging. Health IT and telehealth promotes “care without borders,” Ms. Lamb says. Hospitals, physicians and other providers need this type of consultation without limitations, and this will involve the reshaping of old credentialing and privileging policies.

11. Reimbursement. Assuring that physicians and clinicians are reimbursed for the work they do via telemedicine is essential to make sure healthcare is delivered to areas that need it — and to retain the talented staff that performs the telemedicine functions.

12. Policy. Providers must advocate for coordination at the federal and state levels to support the entire healthcare IT continuum, Ms. Lamb says. ■

ONC Releases Federal Health IT Strategic Plan for 2011-2015

By Sabrina Rodak

The Office of the National Coordinator for Health Information Technology has released an updated strategic plan that outlines five major goals for the next four years.

The five goals detailed in “Federal Health Information Technology Strategic Plan: 2011 – 2015” include the following:

1. Achieve adoption of electronic health records and information exchange through meaningful use of health IT.
2. Improve care and population health and reduce healthcare costs through the use of health IT.

3. Inspire confidence and trust in health IT.

4. Empower individuals with health IT to improve their health and the healthcare system.

5. Achieve rapid learning and technological advancement.

ONC has developed specific objectives for each goal. For example, ONC’s objectives for the first goal are to accelerate adoption of electronic health records, facilitate information exchange to support meaningful use of EHRs and support health IT adoption and information exchange for public health and populations with

unique needs. For the fifth goal, one of ONC’s objectives is to create a learning health system to support quality, research and public and population health.

ONC also delineates several principles for executing the strategy, such as putting individuals and their interests first, supporting health IT benefits for all, focusing on outcomes and encouraging innovation. ■

Report: Healthcare Organizations Under-Prepared to Protect Patients’ Information

By Sabrina Rodak

A report by the Health Research Institute at PricewaterhouseCoopers found evidence suggesting healthcare organizations are currently under-prepared to protect patients’ information.

The report, “Old data learns new tricks: Managing patient privacy and security on a new data-sharing playground,” found that 54 percent of health organizations reported at least one issue with information privacy and security over the past two years. What’s more, more than 55 percent of health organizations surveyed have not

addressed privacy and security issues related to mobile devices and less than 25 percent have addressed social media-related issues.

Improper use of protected health information by an internal party was the most frequently reported issue, with 40 percent of providers reporting an incident of this kind. The high incidence of insiders’ improper use of data may be due to inadequate training: Only 37 percent of organizations include approved uses of mobile devices and social media as part of privacy training, and only 58 percent of providers and

41 percent of health insurers include appropriate use of electronic health records in employee training.

The report suggested healthcare organizations need to adopt a more integrated approach to data privacy and security to protect patients’ information and maintain compliance with federal regulations. PwC said organizations that have used an integrated approach, such as by creating a culture of privacy and security, experienced fewer data breach issues. ■

Study: Providers May Not See Improved Outcomes From Meaningful Use Until Stage 2

By Sabrina Rodak

While meeting stage 1 requirements for meaningful use is unlikely to significantly affect hospital mortality rates, later stages that require greater participation may produce benefits, according to a study published in *Health Affairs*.

Researchers studied the impact of meaningful use criteria on hospital mortality. They found that the stage 1 benchmark that providers use CPOE for at least 30 percent of eligible patients is unlikely to influence rates of death

from heart failure and heart attack among hospitalized Medicare patients. The proposed participation level of 60 percent for stage 2, however, may produce benefits.

Results showed that CPOE use with more than 50 percent of patients was more consistently associated with lower mortality for heart attack and heart failure. The authors conclude that stage 2 CPOE requirements for meaningful use are more likely than stage 1 levels to benefit patients’ health. ■

Avoiding “Stupid” in Healthcare Leadership: Q&A With Glenn Fosdick, CEO of The Nebraska Medical Center

By Bob Herman

Glenn Fosdick, president and CEO of The Nebraska Medical Center in Omaha, has worked in the hospital industry for a long time, graduating from the University of Michigan's hospital administration program in 1976 and managing a few Michigan hospitals along the way. With the way the current health-care system is shaped, though, he has learned a simple concept that has carried him to success: Don't be stupid and stubborn.

Mr. Fosdick, who has been with The Nebraska Medical Center for more than 10 years, has helped oversee the rise of The Nebraska Medical Center as one of the premier academic medical centers in the nation. *U.S. News & World Report* ranks it and its co-owned Nebraska Orthopaedic Hospital as the first- and second-best hospitals in the Omaha region, and the hospital is also a “high-performing” organization in nine adult specialties. Mr. Fosdick shares the goals and challenges his hospital has endured this year, how primary care is affecting the hospital and Nebraska healthcare and how all hospital CEOs must avoid the pitfall of “stupid” and remain open-minded to make progress in today's healthcare landscape.

Q: What are some of the biggest goals for The Nebraska Medical Center this year?

Glenn Fosdick: We have been planning for the past three to four years that something was going to change in how we were reimbursed. We certainly recognized it couldn't keep going on the way it was going. After examining our budget and costs using comparative data of 70 other academic medical centers, we set a goal that we would reduce our costs per adjusted discharge by 15 percent within three years. It's a very substantial change, and we've made a lot of progress on it. Our value management, or decrease in expenses, was reduced by \$41.5 million. We had to do a number of things that were critically important.

One, do not compromise alignment with medical staff. Two, communication was going to be incredibly important in this process. Rumors are always worse than the truth, no matter how bad the truth is. We had to increase our efforts to communicate with employees. And three, my personal responsibility: Prevent us from doing “stupid.” Hospitals have a tendency to “do stupid” in situations like these. I didn't have a lot of

work because our people knew what to do. We weren't doing across-the-board cuts because we didn't want to penalize people that were already working hard. Our goal was not to reduce staffing ratios.

Q: What have been some of the biggest challenges you've faced this year?

GF: Particularly in an academic setting, maintaining alignment with medical staff and coordinating priorities is an issue we need to keep on working on. Overall, we found that the hospital leadership across the board really was well-prepared [for our budgetary process this year]. We worked hard to work on issues of accountability. It was not a difficult budget process. They didn't throw their hands up in air — they were a part of the solution instead of a part of the problem.

One of things that makes finances more challenging is you see an overall reduction in hospital discharges nationally. If we reduced our readmissions to where they should be, you also have to increase market share.

But in the end, we were able to cut \$9 million in our pharmacy through the utilization and collaboration of our medical staff. We also worked with Methodist Hospital in Omaha, and we got our physicians to work together and find a combined contract that saved \$2 million.

Q. How will healthcare reform impact The Nebraska Medical Center, and in what ways will the hospital prepare for the changes?

GF: There are many things we don't know about health reform. The final outcome, whether it will be overridden by the Supreme Court or other courts, etc., but there are three things we are convinced will occur. First, reimbursement will go down. Second, quality-type expectations are going to go up. This includes everything from readmission rates to increased core measures to customer satisfaction. Third, an increased inpatient volume in hospitals will be treated in an outpatient basis. We also have to assume there are some people that were normally admitted to the hospital that won't be anymore.

This is a time of change in healthcare. Leadership in hospitals, administration and medical staff must deal with it but realize we're in this together. We're all being pushed and challenged.



It requires us to look at things differently than historically we have.

Q: The Nebraska Medical Center has been a teaching hospital for the University of Nebraska Medical Center for nearly 14 years. How has this impacted the hospital's overall health goals and results?

GF: It's been positive. We're getting a closer collaboration between the academic physicians and the hospitals. We're looking objectively on what is needed in the community and what the combined clinical and academic needs of the state of Nebraska are.

Q: With many reports discussing a primary care physician shortage forthcoming, how do you see your hospital responding, especially with the UNMC's physician residents and fellows in such close range?

GF: It is a major problem. There are two things that we're being told and agree on. First, you have to find people who are going to practice in rural Nebraska that are from Nebraska. To recruit someone from New York City to come practice in rural Nebraska is somewhat limited. The issue is not rural practice: The issue is rural practicing physicians are essentially on call 24 hours a day, seven days a week. You have to ask, “Is that what you are interested in doing?”, and

for many physicians, it's not. Second, Nebraska is spread out in small communities, and if you have fewer primary care physicians, maybe we should develop more of the physician extenders (physician assistants, nurse practitioners) who could be affiliated with primary care physicians but could be the person on-hand who can provide basic entry care in the community itself.

Q: According to the U.S. News & World Report, The Nebraska Medical Center is high-performing in nine specialties, including cancer, neurology and orthopedics. What are the keys for a hospital to stay at a high-level of performance in numerous specialties?

GF: I think there's been an overall commitment by our medical staff to improve quality but also

to identify what is needed to ensure the physicians can do the best job possible. This includes recruiting the sub-specialties, getting the best equipment and working collectively to create that organizational program. It doesn't happen overnight, and you have to define resources that are necessary.

When it comes to our staff, it's not just one physician. Our high-performing staff is physicians, their supporting staff and the environment that is needed to attract these types of high-quality physicians. We've been fortunate that we have some incredibly talented people here, and in my years of experience, good physicians attract other good physicians.

Q: How do you make improvements in healthcare in Nebraska, especially

considering rural areas are so common throughout the state?

GF: We try to identify programs that have not been available historically. It's normal you compete with other local hospitals for cardiac surgeries and other common things. But we are the only program in the state that does heart, liver and kidney transplants. We are one of four hospitals nationally that do small bowel transplants. Our bone marrow transplant is nationally recognized. According to the National Association of Epilepsy Centers, we are a Level 4 Epilepsy Center, providing the most extensive care for epilepsy procedures. We try to find things that we can do that others aren't doing or can't do. That's an important role you have. ■

From Cop to CEO: Q&A With Chris Van Gorder of Scripps Health (continued from page 1)

in 1978. During your nearly year-long hospital stay that followed, what observations about healthcare jumped out at you most? What drew you in?

Chris Van Gorder: I had been a patient on and off for almost a year. Professionally, I felt vulnerable. I realized I wasn't going to go back and become a policeman, and the future was unknown. Fortunately, I was lucky enough to have been cared for by good physicians and a great staff. I had worked in an emergency room before I became a policeman, so hospitals weren't foreign to me. But it's different when you're lying on a hospital bed. There was an election that year, and I figured there was no way I could vote, but people came in with ballots and allowed me to do that. They really took care of everything. I was very impressed with the care and compassion I received.

I didn't really think about [going into] to healthcare, but when I went back to the police department, they said they were going to retire me. Honestly, I thought I'd like healthcare — that's one thing that drew me into this position. The other is that I needed a job. As a former policeman, I've always been interested in public service, so I applied for a job at the same hospital that had cared for me. The CEO said to me, "You really haven't done that much in healthcare," and I asked him to give me a shot. Give me minimum wage and 90 days and I'll prove to you that you have not made a mistake. After 90 days he said, "You're right. You're good at this." I realized shortly thereafter that I had found my calling. I started as the department director of safety and security at Los Angeles' Orthopaedic

Hospital, earned my credentials and eventually grew into an executive role at Anaheim Memorial Medical Center.

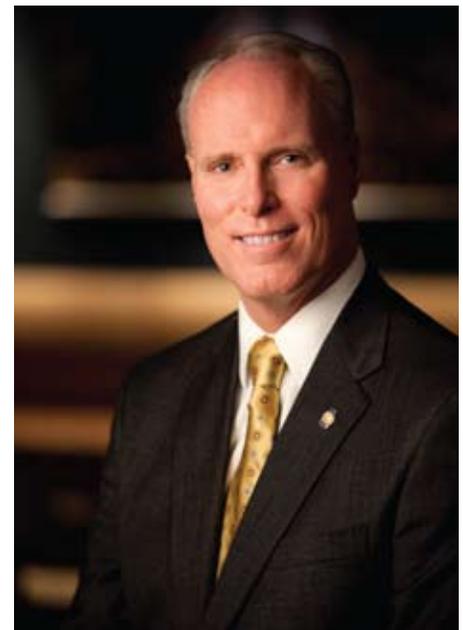
Q: What is the hardest part of your day?

CVG: The nice thing about my job is that my days vary a lot. I started today by mentoring one of our interns who is here from Alabama. Then I talked to the sheriff of San Diego County, then one of our physicians at Scripps Mercy Hospital. I met with the editorial team for the development of a book that is being written about the history of Scripps, and later I'm having a meeting with a hotel CEO. The commonality is that I meet with people. That's really what I do — talk with individuals and groups, communicate direction and motivate people.

The best part of my job is being a teacher and explaining what is going on in healthcare around the country. I enjoy explaining why we need to be more accountable and what is driving healthcare reform. Some people in a hospital are so busy with their work they might not understand what is happening or why. The hardest part of my job? There's nothing individually hard, really — maybe just the very long days.

Q: Do you find yourself working longer days compared to your early days in healthcare?

CVG: I think being CEO has always demanded a lot of time, but probably more today. It's a 24-hour per day job, seven days a week. I'm on my BlackBerry seven days a week. If someone emails me, they'll hear back that same day. The last thing I do every night before I go to bed is answer any unanswered emails. The first thing I do every morning is answer emails that came in overnight.



The people who work with me deserve that responsiveness. I do the same thing on vacation, along with literature searches. Every day of the year, I'll put together a list of stories and reports from various news and healthcare publications and send it to all the senior leadership in the company. That's part of teaching.

Q: How does your background as a police officer influence your leadership style?

CVG: Management is all about people. All police do is work with people. I learned important skills very early on, like how to read body language and how to make quick decisions. As a policeman, you have to make decisions in split seconds. You don't have the luxury of having a day, week or month to decide. I always told my

trainees not to be afraid of making a decision. If you make a mistake, be upfront about it. Taking action without the proper knowledge or information can be dangerous but one can also over-analyze, be indecisive and still kill a company. I have to know when to act quickly and decisively and also when to back off and study the situation a little more. This is all about experience.

Q: It sounds like you've mastered tough-love management. There's an art to that — not everyone can pull it off. Any tips for hospital leaders that are trying to be more stern but supportive?

CVG: It's funny you say "tough love," because I'm not stern at all. I can be, but the bottom line is this: My people know my philosophy, [which is] "miss your targets once, and you won't be here to miss them twice." I have found that people will be very responsive if they understand you're holding them accountable and they understand what they are being held accountable to accomplish. The problem is when senior management doesn't make accountabilities clear or inconsistently enforces accountabilities. Some might call it tough love, but I've never had to terminate someone under this philosophy. Our organization has hit all its targets for 10 years in a row, and we've essentially had the same senior management team for most of that time.

I have always believed that there's a natural tendency for everybody to spend their day doing what they would like to do versus what they have to do. This is particularly true if nobody has told employees what they are accountable for. We make it very clear that there are certain targets we have to meet — financial, quality, patient satisfaction and employee satisfaction, among others. That's what I'm holding the management team and employees accountable for. People focus their time and energy on those tasks, and when that happens, you accomplish them. It's a management issue and responsibility when people miss targets.

Q: A crucial component of your turn-around plan was to improve relationships between management and physicians. What did you learn about physicians and management through the process?

CVG: My father-in-law was a physician, and I spent a lot of time talking to him when he was practicing. He told me to remember physicians believe philosophically they own the hospital. He said, "CEOs will come and go, but physicians will probably spend most of [their] careers at that one hospital. If you treat us with an ownership kind of respect, you will earn back the respect from the physicians." I really think this concept of an adversarial relationship between hospital administrators and physicians is completely false. It's built on this premise that hospital administrators only care about money and not patient care, which is dead wrong, as is the assumption that physicians only care about patient care and not financial issues.

The reason physicians and CEOs can disagree on an issue is because we were trained differently, and since we come from different training we can have different perspectives on issues. I have always believed that if we can find a way to fill the gap of information — physicians giving us important clinical perspectives and administrators sharing the necessary business perspectives — we would agree 99 percent of the time. And I have found that to be true. We really embraced the concept of physician co-management 12 years ago when we established our Physician Leadership Cabinet. To date we have accepted 100 percent of the recommendations and decisions over the 12 years. Three years ago we established the Physician Business Leader Cabinet with our affiliated medical groups and IPAs, and last week we incorporated it into ScrippsCare — our operating board for our ACO.

Q: What is going on at Scripps that excites you most right now?

CVG: There are a lot of things going on here. We just started the construction of the Scripps Prebys Cardiovascular Institute, which will be one of the top cardiovascular centers on the West Coast. It is named for San Diego philanthropist Conrad Prebys, who donated \$45 million to Scripps to fund its construction. It will bring together a number of programs including our wireless technology program, graduate medical education, genomics, clinical research and integrative medicine. It will also bring together the cardiovascular programs from across Scripps Health and Kaiser Permanente in San Diego into one clinical care line.

We're doing some great research in genomics and translational science, and our work around wireless technology is really exciting. We are working with GE to research the VScan, which is a pocket ultrasound that a physician can hold for echocardiograms. Our Proton Therapy Center is underway, which will offer advanced, non-invasive proton therapy to San Diego for the first time. There are so many exciting things. I'm more bullish about healthcare right now than ever before.

Q: Let's say a man or woman is starting their first day as a hospital CEO tomorrow. If you called them and offered one piece of advice, what would it be?

CVG: You're not going to be a hospital CEO. You're going to be a healthcare CEO. You're going to integrate ambulatory care, ambulatory surgery centers, imaging services, ancillary services and many other parts of healthcare. We're trying to keep people well and not just treat them when they're sick — that's part of this move away from being a sick business to a wellness business. We're spending more time and money keeping people well, so that's a brand new world for tomorrow's healthcare leaders. ■

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8 Untraditional Ways to Retain the Best and Brightest in Healthcare

By Gary George, Senior Vice President of Human Resources, Mercy Northern Region

Employee retention is an important element of success in any organization, and even more so in healthcare. Beyond the costs of replacing employees (recent figures estimate the cost of replacing a registered nurse averages about \$64,000), low turnover improves continuity of care for patients and enhances quality. Maintaining a highly competent workforce also improves physician engagement with the health system by allowing physicians to practice more efficiently.

The importance of employee retention in healthcare is compounded by the predicted shortage of healthcare workers. As Baby Boomers age, we expect the demand for healthcare services to increase. At the same time, many of our employees fall into this generation and will cut back their hours or retire altogether, creating a growing need for more qualified healthcare workers. If high-performing employees already in an organization leave because they are not happy or engaged, the continuity and performance of the system could be at risk.

Most hospitals have a number of benefits and other programs aimed at retaining employees (i.e., town hall meetings, service awards and other recognitions, employee events and outings, internal communication initiatives), and we certainly have those at Mercy. However, for the last 10 years we have focused on revving up our efforts around somewhat untraditional activities that result in retention, and the results have been impressive. We've held our turnover rate below 10 percent for the last seven years, placing us in the top quartile among hospitals nationwide.

1. Provide a living wage. At Mercy, we pay employees more than minimum wage for positions that could be compensated at that level — for example, housekeeping and dietary positions. The impact of turnover among these positions can sometimes be overlooked in favor of nurse or other clinician turnover, but continuity among these workers can be just as important. We have established a living wage specific to the four counties where our hospitals are located, and we make sure no employees are compensated below that level.

2. Survey employee engagement, not just satisfaction. Many hospitals regularly perform surveys to gauge employee satisfaction, but employee engagement is more directly related to overall hospital performance. Satisfied employees focus on themselves, while engaged employees focus on themselves and the organi-

zation. They are physiologically committed to the organization's success — the bigger picture. At Mercy, we've partnered with The Gallup Organization to measure employee engagement. Each department within our hospitals then works to develop an impact plan focused on improving certain areas of engagement. The plans are reviewed each month, and new objectives are set as needed.

3. Peer interview new hires. Ensuring each new hire is a fit for the organization, both in terms of technical performance and behavioral fit, is a key element of reducing turnover. We've involved front-line employees in the recruitment process. Based on a recommendation from StuderGroup, a healthcare consulting firm, we began implementing peer interviewing techniques. Under the model, our human resources department screens candidates and then the department manager interviews and selects 2-3 candidates who he or she is willing to hire. These candidates participate in peer interviews with a panel of 2-3 high-performing department employees trained on interviewing techniques. The candidate has the chance to meet with their future coworkers and see who they will be working with and the employees can determine if there's a cultural fit. The employees then have the final say in who is hired. Since implementing peer reviewing, the number of new hires leaving our organization within 90-180 days has dropped considerably.

4. Hold high-performer conversations. While most hospitals have annual employee reviews to assess performance and set development goals, Mercy goes beyond this by requiring all managers to hold annual "conversations" with all employees. Employees are rated as high, middle or low performers. The focus is on high performers. These annual conversations are a more formal way for the manager to "re-recruit" the employee to the organization. Throughout the year, we expect our managers to informally recognize high performers and encourage their development. We recommend managers spend 80 percent of their time with high performers. In most organizations, managers end up devoting a majority of their time trying to improve low performers. Our managers set expectations for low-performers, hold them accountable and then move on to high performers as we believe time spent with them is more beneficial in terms of organizational impact.

5. Deal with low performers. Since revamping our retention efforts, conversations with low performers have changed dramatically. We used



to sandwich their deficiencies between compliments, even if they were superficial ones. Since then, our managers have been trained on how to hold these conversations and are far more direct. Low performers are told what specifically they need to change and by when through a 90-day performance improvement plan. If they don't fulfill the performance improvement plan, they move through the discipline process and ultimately they are asked to leave if their overall performance does not improve to satisfactory level. Employees recognize poor performance is not tolerated. While no one likes to see someone lose his or her job, we've found high performers appreciate our holding everyone to the same standards. Higher performers don't want to be surrounded by low performing employees, and not allowing that has been a real help to us in retaining our best employees.

6. Perform weekly rounding on units. At Mercy, hospital leaders perform weekly rounds for a minimum of one hour on each unit they oversee. For example, each week I round on one of the departments that report to me. I start by visiting the manager and asking if there is anyone I should recognize or any unusual issues in the department I should know about. I then go through the department and chat with employees, guiding my conversation with a list of questions that reflect employee engagement. Managers also spend an hour rounding on their employees each week, assessing engagement and asking about any problems that might lead to disengagement. To employees, the rounding appears very informal, but it's a very formal requirement of our managers and something they've received formal training on.

7. Write thank you notes. Our leaders are asked to write four thank you notes per month by hand, which are sent to the employee's home. Email doesn't cut it. They don't have to be long; they describe the positive action observed, the impact it had on the operations, and why it was appreciated. We send to the home as opposed to handing them out at work because they often get shared with family members or get posted on the refrigerator for other to see. We use the notes not only as a way to thank employees but also as a way to reach out to the employee's family to let them know how their loved one makes a difference in our organization, something that is particularly impactful if the action observed involved picking up an extra shift or another activity that took the employee away from his or her family.

8. Don't ignore emotional demands on healthcare employees. One of the unique concerns healthcare organizations have about their employees is the emotional toll of dealing with sick patients, many who may be facing death. Because of these demands, we have our own, in-house employee assistance program with several professional counselors who are

available to our employees. The counselors are able to address home, work, financial and personal problems, so the negative effect on an employee's life and work is reduced.

While some attrition is natural due to retirement and relocation, these programs have helped Mercy keep our turnover rate below 10 percent for the last seven years. Top quartile performance for healthcare turnover is approximately 11.4 percent or lower. ■

Gary G. George, MBA, is senior vice president of human resources for Mercy in Toledo and Lorain, Ohio. He is responsible for the employee/labor relations, compensation, benefit administration, training and development, employee assistance and recruitment/employment efforts at the nine Mercy hospitals within Northwest and Northeast Ohio. In 2010, Mercy in Toledo received the Human Resource Management Award for large employers from The University of Toledo College of Business, The Employers Association of Greater Toledo, and Toledo Area Human Resource Association. Mr. George has been with Mercy going on 29 years.

From Nurse to CEO: Q&A With Marina Del Rey CEO Fred Hunter

By Sabrina Rodak

Fred Hunter, RN, president and CEO of Marina Del Rey (Calif.) Hospital, has an interesting perspective as a hospital leader because he began his career as a nurse. Mr. Hunter's first nursing job was as a vocational nurse, after which he returned to school to earn his RN and bachelor's degree in nursing. He worked at the bedside and entered into middle management, where he worked in the emergency department and critical care. In 2003, he graduated with a master's in business administration. Below, he discusses how his experience as a nurse has helped shape his leadership style and decisions as CEO of a hospital.

Q: How does your nursing background influence the decisions you make as a hospital CEO?

FH: What drives me is the patient. It's [all] about patient care. I model initiatives around the fact that this is about a patient, and no matter what the strategy might be, it's really about the patient.

When I was working as a director, I would be the one to receive patient complaints. [I learned to understand] that when you listen to patients about their experience it may be right or wrong, but their perception is really what you're dealing with. You have to create an environment so their perception is a positive experience.

Q: How do you involve employees in the hospital's vision?

FH: It is important that the CEO is visible to employees and the medical staff. Unfortunately, it's not an easy task to achieve; it requires time by the CEO to make [him or herself] visible in spite of all the responsibilities the CEO might have. I

do believe that the employees want to see me. I do believe that rounding in all the departments periodically is valuable; it gives that individual, whoever may be on duty at that time, an opportunity to talk to me about their successes, to talk to me about concerns. Employees almost always have great ideas. I believe that they care about the hospital and want to make it better. So that's one mechanism I do utilize.

Another method I incorporate is employee forums. I will try to set up several over a period of a week [on a] quarterly [basis]. Anybody can come as they are able to come, and that gives me and the employees an opportunity to, as a group, interact and dialogue on certain activities within the hospital. I share what I'm thinking, then they can share with me their thoughts on those ideas. They always have an opportunity to give me thoughts on what else we can do for their own agenda. You always need to handle that very delicately. Sometimes, I don't like what I hear, but it's the truth and I need to listen.

Another method that I use, also on a monthly basis, is I have a breakfast with night staff and lunch with day shift staff. All this is really attempting to improve communication. The more opportunity that I have to interact with everyone and for them to interact with me, the better communication is. The breakfasts and lunches are by invitation, and my director of human resources works with me to select random folks from different areas of the hospital. That's actually turned out quite beneficial because now everybody knows each other. People are more comfortable sharing personal aspects of who they are, which is extremely valuable in building trust in the relationships that they have with me.



Q: Is your strategy for engagement different for physicians compared to nurses and other employees?

FH: Medical staff is a bit more formal. I attempt to visit with physicians when I do my rounds. I also try to keep an open door policy at all times. If the medical staff wants to talk to me about anything, I always try to make my time available to them, because their schedules are so strict — there are several hospitals they visit in a day. While they're here at my hospital and want to stop in, it's very important that I allow that audience.

I attend medical staff committee meetings, where I try to update them on activities within the hospital. We [also] have a biannual medical staff meeting. If they have not been able to attend one of the department meetings, they can come to the medical staff meeting where I have an opportunity to speak with them, hear what's happening, share what we're doing and how they can assist and how it impacts them. [In addition,] hallway discussions are always spontaneous and always very useful. ■

Looking Ahead in Healthcare: Finding Optimism in Change

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

It's becoming increasingly obvious to me that healthcare is entering a completely new world, which will involve some pivotal shifts for hospital and health systems. But as I meet with healthcare executives around the country, I am struck by the amount of optimism I see. There seems to be a feeling of acceptance — a sense that change is inevitable, and we must be prepared for it. Even though hospitals and systems face some very sobering issues (see my thoughts on Medicaid below), I think this is the right approach. Change can be very hard and unforgiving, but in the long run, I believe, it is generally for the better.

Here are a few modest observations on confronting the changes we see before us.

1. Act as if the healthcare law is here to stay. Even though the Patient Protection and Affordable Care Act is under challenge in a variety of ways — from the courts, to the Capitol, and ultimately at the ballot box — many healthcare CEOs I talk to are wisely operating under the assumption that it will survive more or less intact, and they will need to deal with it. Those who think the law will just go away should consider “Pascal's wager,” from the French philosopher Blaise Pascal. He stated that even if you don't believe in God, act as if you did. Being wrong could be catastrophic.

Now, I'm not saying the healthcare law is anything like God. Far from it. But in the next few years a multitude of consequential provisions are due to go into effect, including accountable care organizations, an independent payment review board and an insurance coverage mandate for individuals. Some of these provi-

sions are under intense challenge making for a murky future. Healthcare CEOs are having to chart their course through a pea-soup fog. That means, in part, listening to your gut and realizing that, whatever happens, change is a fact of life. Many wise healthcare CEOs are taking steps to prepare their institutions for the road ahead. They are modernizing their systems so that they can operate on a much more efficient basis, not only saving money but also delivering the highest levels of quality. That strategy always makes sense.

2. Medicaid is under threat. In their battles to cut bloated budgets, many state and federal lawmakers want to slash Medicaid spending, but they need to be careful not to throw the baby out with the bathwater. Even now, some public and private hospitals serving the poor and the underinsured are only just getting by. For example, one prominent hospital here in Chicago that heavily depends on Medicaid has been operating with about four days of cash on hand. Talk about narrow margins! If states continue to ratchet down Medicaid reimbursements, many of these essential institutions will go out of business. Where would their patients go? This is a gut-wrenching problem that policymakers don't seem to be addressing. Substantial Medicaid cuts could turn into a very real crisis with no happy ending.

3. Medicare must be revamped. All the tinkering being done with the Medicare program these days disregards one fact: this vast program is desperately in need of a revamp. Medicare is in real danger of running out of money. Clearly, something has to be done to make sure it stays solvent, and yet many in Washington are afraid of making the necessary changes. Until that is done, the program will limp along and its future role will be questionable in terms of policies and reimbursements for hospitals and physicians.

4. Hospitals are consolidating. Hospital consolidation is a huge phenomenon that everybody has been talking about. As reimbursements get tighter and federal regulations require more unified approaches to healthcare, many stand-alone hospitals are joining larger systems. They are coming together to pool their resources. This makes sense.

5. Hospitals look to physicians. The impetus for consolidation seems to come down to hospitals' key resource, their physicians. To dominate their markets, hospitals are using physicians as their lead marketing tool. This



fact was brought home to me when I recently hosted a panel discussion on consolidation featuring Charlie Martin, president and CEO of Vanguard Health Systems; Mike Means, CEO of HealthFirst; Jim Ramsey, president of the University of Louisville; and Don Wegmiller, chairman and co-founder of C-Suite Resources. Their ideas were fascinating and afterwards they received a standing ovation from many in the audience.

The thinking goes that since hospitals and systems' success will be dependent on referrals, they have to actively recruit physician practices. After all, without physician referrals for tests and surgery and other revenue-producing programs, even hospitals with all the latest equipment and finest nurses and technicians would be just empty shells with no income. Of course, how the trend of hospitals hiring physicians works out remains to be seen, but physician-hiring is progressing at a rapid pace and could continue for some time.

How much change can you take? Firsthand, I have seen healthcare changing for decades, but it seems the noise is louder now. I believe the industry will go through a reshaping and a re-ordering process. Despite the many bumps in the road before us, we will end up different. In the end, I sincerely believe, we will become more efficient and more patient-friendly. And nobody can argue with that. ■

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

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Quint Studer: Mastering the Fine Art of Follow-Up

By Lindsey Dunn

Healthcare CEOs today face a remarkably complex environment. The changing external landscape can be daunting, making it all the more critical a hospital or health system's internal operations are seamless. Additionally, because of the large number of priorities that must be balanced by an institution's CEO, he or she must rely on a number of other senior leaders and managers to oversee all the various projects going on simultaneously.

A CEO's performance flourishes when he or she has great lieutenants who perform at the highest level. According to Quint Studer, founder of Studer Group, that's likely to happen when all parties — top leaders, managers and employees at every level — are on the same page. And a big part of making this happen comes down to how well managers and the people they supervise communicate.

Mr. Studer, who has long advised healthcare leaders on performance improvement, makes his first foray into providing guidance directly to employees in his upcoming book, "The Great Employee Handbook" (*Fire Starter Publishing*). A big part of the book is aimed at helping employees in every industry take ownership of their communication with their supervisors (a critical facet of great organizational performance) as well as in other areas of their job.

"Employees aren't sure what the boss wants and are hesitant to inundate the boss with details about a project, says Mr. Studer. "At the same time, the boss wants more information without having to ask or micromanage."

These differing expectations can cause communication breakdowns, Mr. Studer points out. However, such situations can be minimized

when leaders encourage employees to master what he calls, "the fine art of follow-up." Here are a few tips to share with employees:

1. When you receive an assignment, repeat it back. Repeat your understanding of an assignment back to the person who assigned it to you, either in person or through a quick email summary of the project. Doing so will ensure the project begins in the right direction. "Often employees think they hear one thing when the boss may mean another," says Mr. Studer.

Additionally, the "repeating back" technique may help supervisors realize they failed to provide key details of an assignment.

2. Always confirm timing and budget. Although timing and budget restrictions seem a necessary part of any project, supervisors may often assign exploratory projects without providing a deadline or budget guidelines, says Mr. Studer. This can result in unnecessary effort and expense.

"Without specifics, employees tend to want to make the results better than the boss really needs," he says. "They don't want to under-do it — which in itself is an admirable mindset — so they overdo it instead. Sometimes progress is the goal, not perfection."

The bottom line? If the supervisor doesn't assign a deadline or budget guidelines up front, it's best for employees to ask about them.

3. Proactively report project status. Employees should provide status reports frequently and should not assume the boss is too busy for frequent reports. "Bosses want to be apprised of a project's status without having to ask," says Mr. Studer. "Keep sharing where you're at on the to-do list and confirm you're on the right track."

If for some reason a project has to be put on hold or something doesn't go as planned, let everyone associated with the project know right away. For example, Mr. Studer shares an example of a nurse manager who told her department that a piece of equipment would be delivered on a certain day. The nurse manager was later informed it would be delayed but failed to share that information. A week after the scheduled date of arrival, her superiors and staff members finally asked where the equipment was.

"At that point the leader had already lost a week's worth of credibility," says Mr. Studer. "This could have been avoided if she had just checked in regularly with the boss."



4. If in doubt, ask. Employees are often worried about bothering the boss with questions that come up during a project. However, it's better to ask than to make the call yourself and have it end up being the wrong decision, says Mr. Studer. He provides an example: a vendor contract comes in higher than the budget allocated for it, but the vendor has included value-added services outside the scope of the project. Rather than assume it should be thrown out, ask the supervisor for input.

"Sometimes employees don't know all that there is to know," says Mr. Studer. "It's better to ask than to make assumptions."

5. Don't give up until you've tried everything. If a project runs into trouble, prepare a Plan B, says Mr. Studer. Come at the problem from every angle you can think of before you admit defeat. "

Mr. Studer said he was once asked to secure a meeting with a female physician that a health system wanted to recruit, and he could not get her to return his calls. He decided to think outside the box and sent her a dozen roses. She called back immediately.

"I can't do it" is not acceptable," he says. "If you run into a wall, don't go back to your boss with the failure. Exhaust all possibilities first. That's what taking ownership really means." ■

Quint Studer is founder and CEO of Studer Group, a recipient of the 2010 Malcolm Baldrige National Quality Award. He is a recognized leader and change agent in the healthcare industry and has more than 20 years of healthcare experience.

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5 Communication Strategies for Hospital CEOs

By Molly Gamble

Hospital CEOs are experiencing new hurdles in their day-to-day work, brought on by the Affordable Care Act, a shaky economy and a rapidly evolving healthcare industry. While skill sets and workdays might change, one thing will not: hospital CEOs still need to be the visionaries and — more importantly — communicate those ideas.

“There is so much change occurring in the healthcare industry right now, and it is more critical than ever that CEOs use clear and effective communication. Their message must anchor the hospital,” says Marion Crawford, president of Crawford Strategy, based in Greenville, S.C.

Concise and open communication will foster cohesion in the hospital and strengthen its ties to the community. Ms. Crawford shares five communication strategies for hospital CEOs, regardless of their organization's location or bed count.

1. Communicate the vision to your inner circle. The CEO is always the “keeper of the vision,” but the vision must be shared and understood for the CEO to be effective. The first step in sharing the vision is developing it among a core group of lieutenants — the key leaders within the hospital. These individuals can offer feedback and help refine the vision, but most importantly, they will be the primary drivers of its dissemination.

If the vision is dispensed in a dictatorial fashion as opposed to collaboratively, it is less likely to be adopted. “Before the CEO can engage the broader community effectively, the critical inner circle must buy in to the message completely,” says Ms. Crawford. “Engage them, and gather their support, and if they buy in to what you're saying, your ideas will begin to permeate the system,” says Ms. Crawford.

2. Use your “captive ambassador base.”

Do not overlook opportunities to communicate messages broadly to all employees. “Keeping broad employee communication at the forefront of message delivery is key,” says Ms. Crawford. Hospitals and health systems are typically big employers within their respective communities. Therefore, having engaged, informed employees will translate into a healthier relationship with the community.

“People work to get paid, but they also want to be part of something special,” she says. And if the CEO can articulate the organization's objectives and make them feel vested in journey, they will become ambassadors both in the workplace and in the community.

3. Invest in a strong communication team.

Whether through outside or inside resources (or both), hospitals should make the necessary investment in a strong communications team — one that has creative talent, solid writing capabilities and, ideally, experience in the healthcare industry. Integrate that expertise and use it.

Ms. Crawford has multiple hospital clients, and she says that the most important feature of a strong team relationship is non-stop communication. “We talk daily, probably five times a day, and also meet in person regularly. That allows us to understand their nuances or when there is a slight change in tenor,” says Ms. Crawford.

A communication team and hospital that are loosely-connected can run into problems. “Let's say a hospital is entering a transaction, and gives the communication team information about it,” says Ms. Crawford. “Important questions often need to be answered and understood in order for that message to be communicated clearly.” This is where nuances come into play — a communication team may recognize certain risks or op-

portunities a hospital faces if they're in frequent contact. “By talking regularly, I can consider every angle of a development or announcement and refine the message appropriately,” says Ms. Crawford.

4. Listen, listen, listen. Whether it's through town hall meetings, online comments, Intranet feedback or conversations with physicians, CEOs need to sharpen their listening skills and ensure that feedback is not going unnoticed. “These pieces of feedback and communication from stakeholders can help the CEO refine operations, both on a small and large scale,” says Ms. Crawford. Everyone knows that the role of hospitals has changed dramatically in the past 20 years. They've shifted from being inpatient facilities tending to the sick, to flagships of health that hold themselves accountable in their efforts to improve community health. Listening is a keep part of that accountability.

CEOs should do more than accept feedback — they should actively seek it. “At the end of town hall meetings, the CEO for one of our hospital clients welcomes everyone to email him. He tells them he welcomes their input, and with their input and suggestions, the hospital will be able to provide better care. They listen to that,” says Ms. Crawford. Assertively seeking input will help hospital CEOs stay on top of their community's needs and priorities.

5. Embrace all available communication tools in the marketplace.

There are a lot of tools these days — traditional media, social media, physician events, town hall meetings, electronic commercials and much more. “Sometimes, in-person communication is not always possible, and making video a great way to communicate a message,” says Ms. Crawford. This lets people put a face to the hospital, observe body language and hear a voice — whether the video is on YouTube or the hospital's Intranet for employees. Blogs are also an easy way for CEOs to maintain transparency and open communication with both employees and the community while communicating the hospital's message.

This even relates to smaller aspects of a hospital, such as the branding or logos on handouts for education sessions. “Have a hospital spokesperson deliver a short introduction about the organization and where it's headed at the beginning of the class,” says Ms. Crawford. “That message has to be everywhere. It seems so basic and often repetitive, but these small steps add up to the whole.” ■

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Becker's Hospital Review has named "70 Hospitals with Great Cardiology Programs." These hospitals offer outstanding heart care, and the *Becker's Hospital Review* editorial team selected them based on clinical accolades, quality care and contributions to the field of cardiology. These hospitals have been recognized for excellence in this specialty by reputable healthcare rating resources, including *U.S. News & World Report*, HealthGrades, Thomson Reuters, the American Heart Association, the American Stroke Association and the American Nurses Credentialing Center. Note: This list is not an endorsement of included hospitals or associated healthcare providers, and hospitals cannot pay to be included on this list. Hospitals are presented in alphabetical order.

Abbott Northwestern Hospital (Minneapolis).

Advocate Good Samaritan Hospital (Downers Grove, Ill.).

Allegheny General Hospital (Pittsburgh).

Aurora St. Luke's Medical Center (Milwaukee).

Banner Good Samaritan Medical Center (Phoenix).

Barnes-Jewish Hospital/Washington University (Saint Louis).

Beaumont Hospital (Royal Oak, Mich.).

Beth Israel Deaconess Medical Center (Boston).

Boca Raton (Fla.) Regional Hospital.

Brigham and Women's Hospital (Boston).

Carolinas Medical Center (Charlotte, N.C.).

Cedars-Sinai Medical Center (Los Angeles).

The Christ Hospital (Cincinnati).

Cleveland Clinic.

Duke University Medical Center (Durham, N.C.).

Emory University Hospital (Atlanta).

Evanston (Ill.) Hospital.

Geisinger Medical Center (Danville, Pa.).

Greenville (S.C.) Memorial Hospital.

Gundersen Lutheran Medical Center (La Crosse, Wis.).

Hackensack (N.J.) University Medical Center.

Hahnemann University Hospital (Philadelphia).

Henrico Doctors' Hospital (Richmond, Va.).

Hospital of the University of Pennsylvania (Philadelphia).

Johns Hopkins Hospital (Baltimore).

Lake Health (Concord, Ohio).

Lancaster (Pa.) General Hospital.

Loyola University Medical Center (Maywood, Ill.).

Martin Memorial Medical Center (Stuart, Fla.).

Massachusetts General Hospital (Boston).

Mayo Clinic (Rochester, Minn.).

Memorial Hermann-Texas Medical Center (Houston).

Methodist Hospital (Houston).

Morton Plant Hospital (Clearwater, Fla.).

Mount Sinai Medical Center (New York City).

Munson Medical Center (Traverse City, Mich.).

New York-Presbyterian Hospital (New York City).

Newark (N.J.) Beth Israel Medical Center.

Northeast Georgia Medical Center (Gainesville).

Northside Medical Center (Youngstown, Ohio).

Northwestern Memorial Hospital (Chicago).

NYU Langone Medical Center (New York City).

Ochsner Medical Center (New Orleans).

Ohio State University Hospital (Columbus).

Presbyterian Hospital (Charlotte, N.C.).

Ronald Reagan UCLA Medical Center (Los Angeles).

Rush University Medical Center (Chicago).

Scripps Memorial Hospital La Jolla (Calif.).

Sentara Norfolk (Va.) General Hospital.

Shands at the University of Florida (Gainesville, Fla.).

St. Francis Hospital (Roslyn, N.Y.).

St. Luke's Episcopal Hospital (Houston).

Stanford Hospital and Clinics (Palo Alto, Calif.).

Tampa (Fla.) General Hospital.

Thomas Jefferson University Hospital (Philadelphia).

Union Memorial Hospital (Baltimore).

The University of Arizona Medical Center – University Campus (Tucson).

University of California, San Francisco Medical Center.

University of Chicago Medical Center.

The University of Kansas Hospital (Kansas City, Kan.).

University of Maryland Medical Center (Baltimore).

University of Michigan Medical Center (Ann Arbor).

University of Pittsburgh Medical Center.

University of Texas Southwestern Medical Center (Dallas).

Vanderbilt University Medical Center (Nashville, Tenn.).

Virginia Commonwealth University Medical Center (Richmond).

Wake Forest University Baptist Medical Center (Winston-Salem, N.C.).

Washington (D.C.) Hospital Center.

Winthrop-University Hospital (Mineola, N.Y.).

Yale-New Haven (Conn.) Hospital. ■

Hospital & Health System Transactions

Alexian Brothers Health System, based in Arlington Heights, Ill., and **Ascension Health**, based in St. Louis, signed a definitive agreement for ABHS to join the Ascension system. The agreement now goes to the Illinois Health Facilities and Services Review Board for review.

Beaufort County (N.C.) commissioners approved the lease and potential sale of **Beaufort County Medical Center** to **University Health Systems**, based in Greenville, N.C.

Denver-based **Centura Health** plans to sell St. Anthony Granby (Colo.) Medical Center for \$2.6 million to **Kremmling (Colo.) Memorial Hospital District**. The sale is part of a new affiliation agreement between the two parties.

Franklin, Tenn.-based **Community Health Systems** sold two of its Oklahoma hospitals to Tulsa, Okla.-based **Ardent Health Services**. South-Crest Hospital in Tulsa and Claremore (Okla.) Regional Hospital are now affiliates of Hillcrest HealthCare System, which is part of Ardent.

Cooley Dickinson Hospital in Northampton, Mass., is in active discussions with larger systems, including Boston's **Massachusetts General Hospital** and Nashville, Tenn.-based **Vanguard Health Systems**, regarding a merger. The hospital is now looking for a relationship where a larger partner becomes the owner.

Danville, Pa.-based **Geisinger Health System** signed a definitive agreement to merge with **Bloomsburg (Pa.) Health System**. The agreement is pending regulatory approval.

The Federal Trade Commission signed off on Naples, Fla.-based **Health Management Associates'** acquisition of Knoxville, Tenn.-based **Mercy Health Partners**.

Plano, Texas-based **LHP Hospital Group** signed a letter of intent to merge a previously announced joint venture between LHP, **Saint Mary's Health System** and **The Waterbury Hospital**, both in Waterbury, Conn.

MedCath entered into a definitive agreement to sell its Hualapai Mountain Medical Center in Kingman, Ariz., to **Kingman Regional Medical Center**.

Chesterfield, Mo.-based **Mercy** struck an agreement with **Logan Medical Center** in Guthrie, Okla., to acquire it and its four clinics.

Chicago's **Mercy Hospital and Medical Center** is in talks to merge with Novi, Mich.-based **Trinity Health** — the same Catholic system that purchased Maywood, Ill.-based Loyola University Health System in July.

Massachusetts Attorney General Martha Coakley's Office approved the transfers of **Morton Hospital** in Taunton and **Quincy (Mass.) Medical Center** to an affiliate of **Steward Health Care System**.

Brentwood, Tenn.-based **RegionalCare Hospital Partners** signed a definitive agreement to merge with Nashville, Tenn.-based **Essent Healthcare**. The merger will create a seven-hospital system.

Brooklyn-based **Revival Home Health Care** will operate **Peninsula Hospital** in Far Rockaway, N.Y., and extended an \$8 million line of credit to the hospital to keep it open. Peninsula Hospital will file for bankruptcy as part of its plans for restructuring, which are being led by Revival.

St. Benedicts Family Medical Center in Jerome, Idaho, approached Boise, Idaho-based **St. Luke's Health System** to discuss merger opportunities. St. Benedicts and St. Luke's have not made any final decisions.

A pending merger between three hospital systems — Louisville-based **University Hospital**, **Jewish Hospital & St. Mary's HealthCare** and Lexington-based **St. Joseph Health System** — to create a statewide Catholic health system was cleared by the Federal Trade Commission. The deal still requires approval by Gov. Steve Beshear and the Catholic Church.

The board of directors at **University of North Carolina Health Care**, based in Chapel Hill, voted to decline WakeMed's proposal to acquire Rex Healthcare in Raleigh, N.C. — part of UNC Health Care.

Nashville, Tenn.-based **Vanguard Health Systems** finalized the terms of a joint venture with **Valley Baptist Health Systems**, based in Harlingen, Texas. Under the deal, Vanguard acquired a 51 percent interest in the assets of VBHS.

The California attorney general denied the sale of **Victor Valley Community Hospital** Ontario, Calif.-based **Prime Healthcare Services Foundation**, saying the deal would not be in the public interest. The AG reportedly did not give specific reasons for the decision.

The **Westerly (R.I.) Hospital** and **Lawrence & Memorial Hospital** in New London, R.I., are researching a strategic alliance to align services. Leaders from the hospitals said the agreement is a non-binding letter of intent to explore an affiliation.

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Hospital & Health System Executive Moves

Ron Anderson, CEO of Dallas' Parkland Memorial Hospital, will be moved to another role by the end of the year.

SSM St. Mary's Health Center in Richmond Heights, Mo., named **Kathleen Becker** president.

Rick Bockmann and **Gwen Matthews** have been appointed CEOs of Frank R. Howard Memorial Hospital in Willits, Calif., and Ukiah (Calif.) Valley Medical Center, respectively. Both hospitals are part of Adventist Health, headquartered in Roseville, Calif.

Martin Bonick, president of the Jewish Hospital Medical Campus and senior vice president of Jewish Hospital & St. Mary's HealthCare in Louisville, Ky., resigned.

Chicago's Resurrection Health Care President and CEO **Sandra Bruce** was appointed president and CEO of the new organization which will be formed by the merger of Provena Health in Mokena, Ill., and Resurrection.

President and CEO **Gregory Burfitt** of Allegheny General Hospital and Western Pennsylvania Hospital, both in Pittsburgh, is stepping down from his role.

Paul Castillo has been selected as the new CFO of University of Michigan Health System, based in Ann Arbor, effective in November.

Children's Hospital of Wisconsin in Milwaukee promoted COO **Cindy Christensen** to president of the hospital.

Mike Dorsey, president and CEO of Providence Medical Center in Kansas City, Kan., and St. John Hospital in Leavenworth, Kan., resigned from his post.

Dr. **Willem de Villiers** was named chief administrative officer of University of Kentucky HealthCare's Good Samaritan Hospital.

Gary Duncan, president and CEO of Freeman Health System in Joplin, Mo., announced he will retire in 2012.

Steven D. Edwards will assume the position of president and CEO of CoxHealth, based in Springfield, Mo., following Robert Bezanson's retirement in December.

Joseph Felkner, CFO of Lehigh Valley Health Network based in Allentown, Pa., resigned.

Larry Goldberg, CEO of the Vanderbilt University Medical Center in Nashville, Tenn., was appointed president and CEO of Loyola University Health System in Maywood, Ill.

Cleveland Clinic officials appointed **Michael J. Habowski** as president of the Ashtabula, Ohio-based ACMC Healthcare System, which consists of Ashtabula County Medical Center, Glenbeigh and Ashtabula Regional Home Health.

David Kilarski was named CEO of FirstHealth of the Carolinas, based in Pinchurst, N.C.

HCA announced that **Lawrence H. Kloess, III**, president of the company's TriStar Division, will retire Dec. 31.

Robert Parker was promoted from interim CEO to full-time CEO of Meadowview Regional Medical Center in Maysville, Ky.

Jewish Hospital & St. Mary's HealthCare, based in Louisville, Ky., named **Jim Parobek** president of Sts. Mary & Elizabeth Hospital and senior vice president of clinical innovation.

Frank Powell, CFO of Houston Healthcare in Warner Robins, Ga., resigned.

Kevin Tabb, MD, was tapped to serve as the next president and CEO of Beth Israel Deaconess Medical Center in Boston.

Ron Webb, CEO at Holy Rosary Healthcare in Miles City, Mont., retired.

Doctors Hospital of Augusta (Ga.) named **Doug Welch** CEO, effective Oct. 1.

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