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BECKER'S
Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

November/December 2012 • Vol. 2012 No. 9

The 12 "Biggest" Hospital Stories of 2012

2012 has been quite a year for healthcare and for hospitals. During the last 12 months, the Supreme Court upheld President Obama's signature healthcare reform legislation and several of its provisions that most impact hospitals went into effect. These changes, as well as a host of other forces, including reimbursement pressures and growing demands upon providers, have caused providers to take a hard look at our country's healthcare delivery system and begin to take steps toward some sort of change. While there is no crystal ball that allows us to see what healthcare delivery will look like 20 years down the road, one thing is for certain: 2012 was certainly a year that will be remembered as a year of significant change. Here is a look back at the biggest hospital-industry stories this year.

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Managing the Transition to Value-Based Reimbursement: 8 Core Strategies to Mind the Gap

By Sabrina Rodak

There is no shortage of challenges in healthcare today. One of the most significant challenges is managing what economic futurist Ian Morrison calls "life in the gap," according to an American Hospital Association report. The "gap" is this awkward period of time when healthcare organizations are being pressured to lower costs and improve quality, but remain paid largely on a fee-for-service system.

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Pension Management Predicaments? 3 Dominant Hospital Pension Strategies

By Bob Hermann

After the economic collapse of 2008, the word "pension" became a somewhat frightening term. Many individuals had lost significant portions of theirs, and many organizations that still had successful pension plans — including hospitals and health systems — realized it was becoming harder to deal with future liabilities.

Pension plan strategies have evolved even more rapidly within the past year. Sheldon Gamzon, principal at PricewaterhouseCoopers who has dealt with the pension plans of several hospitals and health systems, said last year, hospitals planned on remaining committed to their pension structure because traditional pensions were so important to their culture and, more importantly, their employees, nurses and unions. However, unfunded pension liabilities have been killing balance sheets.

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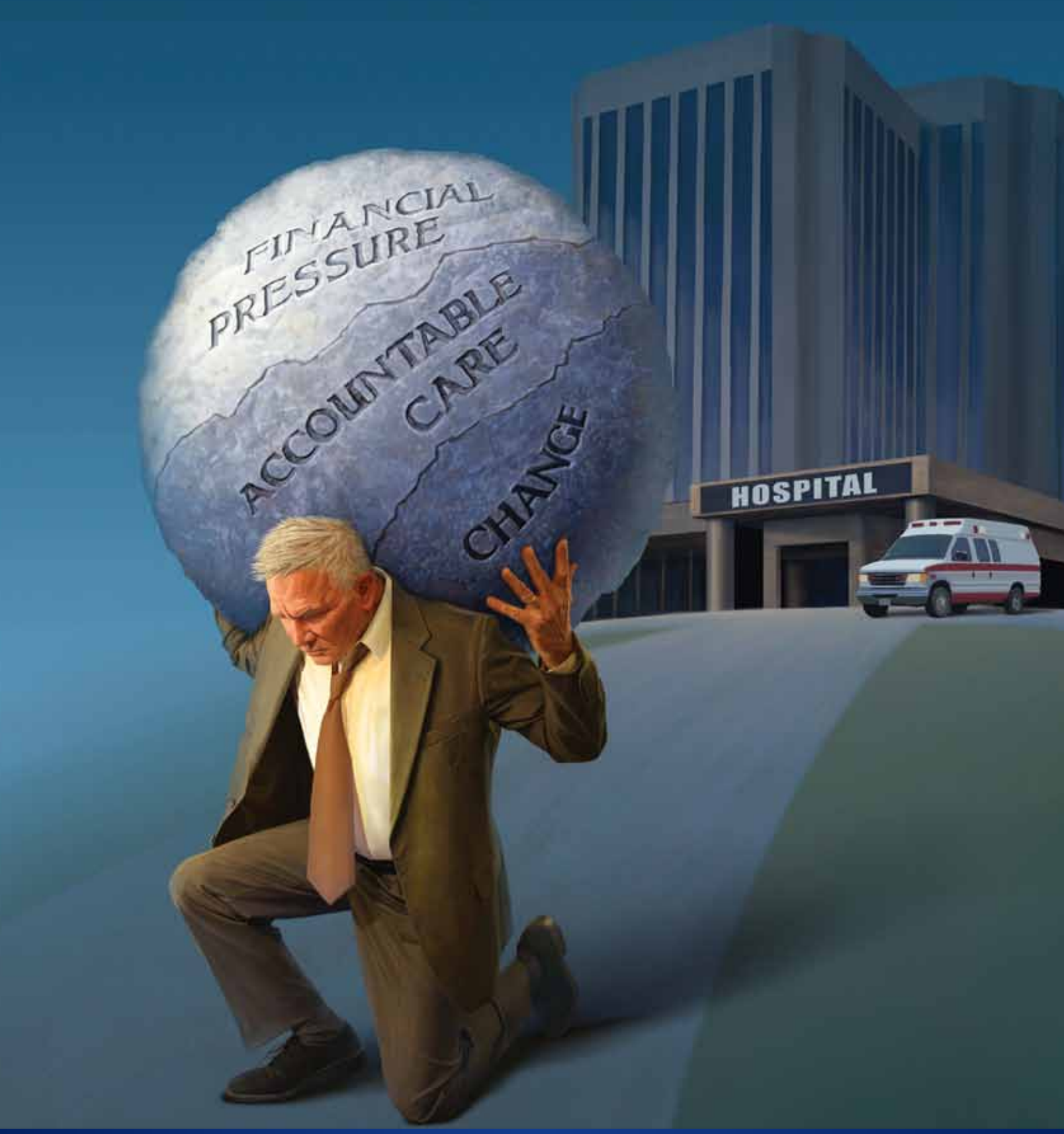

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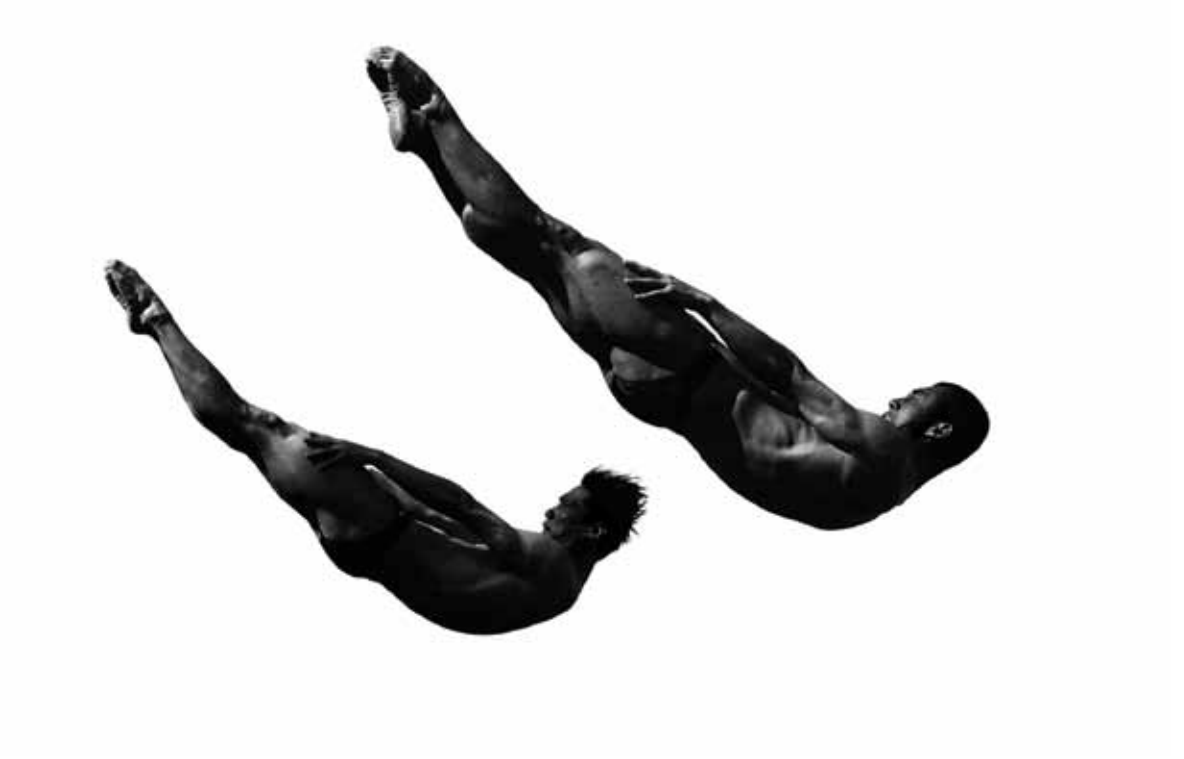

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FEATURES

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Becker's Hospital Review

BECKER'S Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

Publisher's Letter

Becker's Hospital Review to Expand in 2013

Becker's Hospital Review will expand in several ways in 2013. We believe these changes will provider greater value to our readers, while continuing to grow our brand as the leading business and legal publication in the healthcare space.

1. The magazine will expand to 12 print issues next year, an increase from the nine per year we currently publish. The change will mean *Becker's Hospital Review* will be available in your mailbox and via our digital editions each and every month.

2. We've recently increased the frequency of the Becker's CFO Report E-Weekly from once per week to twice weekly (sent Monday and Thursday). This E-Weekly is aimed at CFOs, hospital controllers, financial professionals and the revenue cycle audience. We will continue to publish the Becker's CEO Report E-Weekly once per week. We believe the change is consistent with our goal of being the leader in reaching hospital CEOs and CFOs. In order to expand the content aimed at these two roles, we have also added another very smart writer/reporter to our editorial team who will focus solely on CEO and CFO issues.

3. We plan to expand the Becker's Hospital Review Annual Meeting to a two-and-a-half day affair in May 2013. We currently have signed up Lou Holtz as a keynote speaker for the event, along with Bret Baier, anchor of FOX News Channel's "Special Report with Bret Baier."

4. We will continue to host the Becker's Hospital Review CEO Strategy Roundtable. The event is a new addition for 2012, and will take place Nov. 1 at the Ritz Carlton in Chicago. The event will feature a panel with 11 outstanding hospital CEOs and Quint Studer discussing hospital and health system strategy. The roundtable will be moderated by Chuck Lauer, former publisher of *Modern Healthcare*, and myself.

5. We will continue to work to grow our web and E-Weekly traffics. We are pleased to report that all of our E-Weeklies and websites are reaching record numbers in terms of opens and views. We hope to continue to carry this momentum into 2013.

If you have any questions about *Becker's Hospital Review's* strategy and new offerings, please contact Jessica Cole, president and CEO, or Lindsey Dunn, editor in chief, at (800) 417-2035.

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The 12 "Biggest" Hospital Stories of 2012 **(continued from page 1)**

1. Supreme Court upholds healthcare reform. In what was perhaps the biggest story in healthcare this year, the Supreme Court upheld the Patient Protection and Affordable Care Act as constitutional in a 5-4 vote in June. Chief Justice John Roberts joined with Justices Stephen Breyer, Ruth Bader Ginsburg, Elena Kagan and Sonia Sotomayor in the majority.

The most controversial part of the PPACA, the individual mandate, was upheld in the decision, under Congress' power to lay and collect taxes, Chief Justice Robert explained in the decision.

The Medicaid expansion provision was limited, but not invalidated, by the decision. The majority stated that Congress cannot penalize states that choose to not participate in Medicaid expansion, therefore making it optional for states to participate.

Because the PPACA was upheld by the Supreme Court, the bill's provisions continued to go into effect in 2012. Eleven provisions of the PPACA went into effect this year, most of which directly affect hospital and healthcare providers.

Six provisions of the act went into effect Jan. 1, several of which apply to hospitals and healthcare providers. Medicare launched three separate programs for accountable care organizations, and there are now more than 160 Medicare ACOs. Medicare advantage plan payments that provide bonus payments to high-quality plans also began. Procedures for screening, oversight and reporting for providers that participate in Medicare, Medicaid and CHIP were established under the fraud and abuse prevention provision. The Medicare Independence at Home demonstration and Medicaid payment demonstration projects also started at the beginning of the year, as did annual fees on the pharmaceutical industry.

In March, data collection to reduce healthcare disparities went into effect. This provision requires providers to enhance collection and reporting of data on race, ethnicity, sex, primary language, disability status and underserved rural populations.

Two provisions took effect in October. Medicare value-based purchasing began, which established a value-based purchasing program to pay hospitals based on performance on quality measures, and requires plans to be developed to implement value-based purchasing programs for skilled nursing facilities, home health agencies and ambulatory surgery centers. Also in October, reduced Medicare payments for excessive hospital readmissions began.

During 2013, 15 more provisions of the PPACA are set to go into effect.

2. 2012 presidential election puts Medicare, healthcare in spotlight. This past year has been rife with partisan battles over healthcare, especially battles centered on President Barack Obama's sweeping healthcare reform legislation, the Patient Protection and Affordable Care Act. This comes as no surprise since 2012 is a presidential election year — and a year full of healthcare reform that included more work toward accountable care organizations, health insurance exchanges, Medicare readmissions programs and more.

At the Republican National Convention in Tampa, Fla., in late August, the Republican Party adopted its official platform, and it included several main points related to healthcare. The drumbeat sounded by Mitt Romney, Paul Ryan and other GOP leaders was that if the GOP took the White House in November, it would repeal the PPACA. Republican leaders also said they

would transition Medicare to a premium-support model, increase the Medicare eligibility age, institute block grants for Medicaid and more.

At the Democratic National Convention, President Obama, Vice President Joe Biden, former President Bill Clinton and others touted the PPACA and the successful reforms it has brought and will bring. Democratic leaders said they will continue to solidify the Medicare and Medicaid programs through provider-based reforms and expansion of health coverage. Democrats also lauded President Obama for leading the "most successful crackdown on healthcare fraud ever," as $100 billion from fraudulent healthcare schemes has been recovered under his administration, and for continuing to put women's health at the forefront.

When it comes to healthcare, though, the 2012 election cycle focused on Medicare more than any other program. As the single-largest payor in the United States, and one that many hospitals rely on, both sides of the aisle have vowed to keep the best interests of Medicare beneficiaries in mind while making the program more "solvent" for future generations. As of press time, the results of the election had not been finalized, but this upcoming year will be telling if the nation's political leaders follow through on Medicare reforms — ranging from shared savings programs to lowering the cost of Medicare cases — both for beneficiaries and healthcare providers.

3. U.S. healthcare costs continue to rise, while Medicare funding hits brick wall. If there was one certainty for hospitals and healthcare organizations in 2012, it was that the cost of healthcare continued to rise. In June, CMS released its report on national healthcare expenditures, and the report noted that national healthcare expenditures grew 3.9 percent in 2011, a relatively modest growth rate amidst a sluggish economy. The total NHE figure was $2.7 trillion, which was roughly 18 percent of gross domestic product.

In 2011, Congress and President Barack Obama also tried to finalize a deal on how to reduce the nation's mounting debt, but the so-called "supercommittee" failed to reach a bipartisan consensus on a deficit deal. The result of those failed negotiations was the Budget Control Act of 2011, which essentially said all government agencies — including Medicare — would be subjected to sequestration starting in 2013 unless Congress can figure out a new deal. In September, the White House's Office of Management and Budget unveiled how those sequestration cuts would impact healthcare providers. Starting January 2013, hospitals and other providers would lose roughly $11.1 billion in Medicare payments due to sequestration, and the National Institutes of Health would have to "halt or curtail" most of its major scientific research projects. This came amidst the annual report from the Medicare Board of Trustees, which estimated the hospital trust fund — or Medicare Part A — has an insolvency date of 2024.

Sequestration was not the only damper on Medicare rates for healthcare providers. The sustainable growth rate, which is the formula used to determine Medicare physician payments, also caused a stir at the beginning of the year after Congress couldn't agree to a permanent fix. In February, President Obama finally signed the Middle Class Tax Relief and Job Creation Act of 2012, which kept Medicare physician payment rates at their current rate through Dec. 31, 2012. Physicians would've incurred payment cuts of 27.4 percent without the temporary fix, which will cost roughly $18 billion over 10 years. To account for those costs, Congress created several other provisions in the Middle Class Tax Relief and Job Creation Act of 2012. For example, hospitals' and skilled nursing facilities' bad debt reimbursement rates from Medicare were reduced from 70 percent to 65 percent, starting in FY 2013, and starting in FY 2021, Medicaid disproportionate share hospital payments will be rebased, which will cut funds by $4.1 billion. A permanent SGR fix will now cost roughly $245 billion, according to the Congressional Budget Office.

Medicare and Medicaid funding will always be a major issue for hospitals and healthcare providers, and 2012 proved to be an especially hectic year. As healthcare reform and other healthcare issues continue to rise to the top of the national dialogue, providers are increasingly monitoring the situation as new reimbursement and funding initiatives are directly impacting their bottom lines and financial livelihoods.

4. Readmissions and "value" now impact reimbursement. Under the Patient Protection and Affordable Care Act's Readmissions Reduction Program, which began Oct. 1, hospitals are penalized for high readmission rates for heart attack, heart failure and pneumonia. The first year's penalties will range from 0.01 percent to 1 percent of base Medicare reimbursements. Beginning in October 2013, the maximum penalty will increase to 2 percent.

A report released in September by the Medicare Payment Advisory Commission found that 67 percent of hospitals will be penalized for high readmission rates, 9 percent of which will face the maximum 1 percent penalty. Analysis by *Kaiser Health News* found the penalties will cost hospitals a total of $280 million in Medicare funds. Shortly after this rule took effect, CMS issued a notice admitting to a technical error that will cause an average 0.02 percent change in readmission penalties. Due to the error, 1,422 hospitals will lose more money than previously expected and 55 hospitals will lose less money, according to a *Kaiser Health News* analysis.

To avoid Medicare cuts and improve the health of their communities, hospitals are scrambling to develop strategies to prevent readmissions. Hospitals are leveraging health IT, partnering with post-acute care providers and educating patients more thoroughly at discharge.

In addition to readmissions, hospitals are also focusing more on the patient experience and patient satisfaction, as scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey will be one of the contributing factors to value-based purchasing payments, which took effect Oct. 1. Under VBP, hospitals' diagnosis-related group payments from Medicare will be reduced 1 percent to create a pool of incentive payments. Hospitals that meet clinical and HCAHPS measures will receive a portion of the incentive payments.

5. Hospitals take on more financial risk. The shift from a fee-for-service payment model to pay-for-performance is leading hospitals to take on increasing amounts of risk. In the future, it's expected that payments will not be tied to volume, but rather to outcomes and value. In an effort to prepare for this, many hospitals are beginning to take on some level of risk and hope to profit financially from doing so. Generally, the higher percentage of payment hospitals risk on performance scores, the greater the potential reward.

One of the ways hospitals are beginning to test the waters of risk is through accountable care organizations. The Medicare accountable care organization model has two tracks, each with different levels of risk. Medicare ACOs in the shared savings only track have the potential to earn up to 50 percent of the amount saved by reducing its Medicare expenditures. In contrast, Medicare ACOs in the shared savings/losses track can receive up to 60 percent of the savings. Medicare ACOs only involve some risk, however, as providers will continue to be paid under the fee-for-service system. Commercial ACOs function similarly, but can use a different non-incentive-based payment system besides the fee-for-service system to complement the incentive payments.

Another model of risk is bundled payments, which give a lump sum payment for an episode of care, and the payments are then distributed to the providers who were involved in the episode of care. Under this model, hospitals can standardize protocols to drive higher quality and lower cost to net a greater amount of the bundled payment. While the model presents an opportunity to lower costs, it also puts the hospital at risk for other providers' actions. If one member of the team does not follow through and payments are reduced, everyone, including the hospital, suffers.

Hospitals are also taking on risk by offering health insurance products. More hospitals are exploring offering their own insurance, and others are entering into agreements with traditional insurers to offer some variety of value-based insurance product. For example, in September,

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California-based Sutter Health applied for a license to form a health maintenance organization catering to small and midsize employers.

One option for hospitals interested in taking on risk as a health insurer is participating in a consumer-operated and oriented plan program, or CO-OP, a program under the PPACA. A CO-OP is a consumer-governed, non-profit health insurer that is designed to align physicians and hospitals under the same health plan. Recently, Boston-based Tufts Medical Center, its physician network called the New England Quality Care Alliance and Nashville, Tenn.-based Vanguard Health Systems partnered to create a CO-OP called the Minuteman Health Initiative. They received an $88.5 million CO-OP loan from CMS to fund this initiative.

6. Accountable care organizations continue to grow. In 2011, many organizations began laying the groundwork to supply populations with accountable care. In 2012, accountable care organizations grew in number and popularity through the three core Medicare ACO models and commercial ACOs.

In December 2011, 32 organizations were accepted into the Pioneer ACO Model with their performance period beginning in January. The Pioneer program was designed for organizations already experienced in coordinating care across settings. In April, CMS named the first Medicare Shared Savings Program ACOs. Twenty-seven ACOs were accepted into the program, and their first performance period began April 1. CMS added 88 more Shared Savings ACOs in July, and that group's performance period started July 1.

The first group of 20 Advanced Payment ACOs was also announced in April. The Advanced Payment Model is designed specifically for physician-based and rural providers that are participating in the Shared Savings Program. Under this model, participants receive upfront and monthly payments to use as investments in their care coordination infrastructure.

CMS also announced that applications for organizations to become Medicare ACOs would be accepted every year moving forward. The 2013 applications were accepted through September.

Major commercial payors, such as Blue Cross Blue Shield, Cigna and Aetna, have formed commercial ACOs this year as well. In fact, Cigna has announced that the company is on pace to create 100 ACOs by 2014 and bring accountable care to 1 million customers.

Because ACOs are so new, it is not yet clear if this model of care will be successful in the long run. But for now, many hospitals, health systems and payors are embracing the change.

7. The government continues its focus on fraud-fighting efforts. The Obama administration's concentrated focus on healthcare fraud prevention spurred some milestones in the past year. In April, the administration announced that HHS and the Department of Justice recovered more than $4 billion in healthcare fraud judgments in fiscal year 2011 — an all-time high. In May, federal authorities charged 107 people nationwide for their alleged participation in a $452 million Medicare fraud scheme. The takedown marked the highest amount of false Medicare billings in a single fraud bust in the three-year history of the multi-agency Medicare Fraud Strike Force. In July, the administration announced an innovative partnership with private insurance companies, including Humana, UnitedHealth Group and WellPoint, to track medical claims in real time and better identify suspicious billing patterns.

Although fraud prevention is an inarguably important pursuit that garners support on both sides of the political spectrum, some healthcare providers have found certain fraud-fighting tactics burdensome. For instance, the PPACA includes a provision called "Credible Allegation of Fraud," which authorizes states to halt Medicaid payments if fraud allegations have a reasonable sign of reliability. By July, the Office of Inspector General had placed payment holds on 88 providers from the beginning of the year. Physicians affected by the hold said the Medicaid freeze brought their practices to a sudden halt, and the strategy allowed them too little due process.

The breadth and financial gains of Medicare recovery audits grew this past year, as well. In the first quarter of fiscal year 2012, Medicare Recovery Audit Contractors took back $397.8 million in overpayments. That is roughly half the amount RACs collected in *all* of fiscal year 2011 ($797.4 million). Hospitals also reported greater scope and frequency of Medicare RACs in 2012: About 87 percent of hospitals experienced RAC activity in the first quarter of 2012 alone. Hospitals also reported an increase in the number of medical record requests from Medicare RACs — an increase from roughly 306,350 in third quarter 2011 to 447,520 in first quarter 2012.

States were also required to contract with one or more Medicaid RACs to review Medicaid claims by the beginning of 2012. There have not been substantial progress reports from the program given its relative youth, but the government expects Medicaid RACs to save $2.1 billion over five years.

8. More scrutiny — both federal and public — about the necessity of care. In September, the Department of Justice and CMS sent notices to hospitals across the country, encouraging them to self-audit and determine if they had improperly billed Medicare for implantable cardioverter defibrillators that did not meet medical coverage standards. The devices, which regulate irregular heart rhythms, cost approximately $40,000 each.

The agencies shared the ICD Investigation Medical Review Guidelines/Resolution Model, which contains six categories of circumstances under which ICDs can be implanted in Medicare patients and receive reimbursement. The DOJ will evaluate each hospital's situation individually to determine damage multipliers and penalties, which are influenced by the existence or level of patient harm, the hospital's patterns of billing, compliance efforts and evidence of hospital knowledge. Hospitals and physicians may face significant penalties under the investigation: Under the False Claims Act, the DOJ can collect triple the amount of monetary damages for unnecessary surgeries.

Aside from the federal agencies' call for self-audits, the press played a role in discussions about necessity of care in 2012. *The New York Times* made waves with two lengthy investigative reports in August 2012, both focused on Nashville, Tenn.-based Hospital Corporation of America. The first report questioned the for-profit hospital chain's cardiac care while the second scrutinized its emergency departments. For the former, the *Times* obtained an internal HCA memo regarding results of the company's 2010 internal investigation, which found roughly half of 1,200 cardiac procedures performed were on patients without significant heart disease.

9. Merger and acquisition activity among hospitals and health systems remains very active. Lower reimbursement rates, increasing operating costs related to compliance, technology, physician employment and movement toward accountable care models acted as drivers for continued consolidation in 2012. A variety of deals were announced and finalized, ranging from full-ownership acquisitions to joint ventures and affiliations with little ownership change for the participating hospitals. Some of the most notable deals involved large health systems and multiple hospitals.

In January, Jewish Hospital & St. Mary's HealthCare in Louisville, Ky., and Saint Joseph Health System in Lexington, Ky. — which is owned by Englewood, Colo.-based Catholic Health Initiatives — announced a merger to form KentuckyOne Health. The merger originally included University Hospital in Louisville, but Kentucky Governor Steve Beshear rejected the proposed three-way deal because it would have combined a public safety-net hospital with a Catholic healthcare company.

In early June, NYU Langone Medical Center and Continuum Health Partners, both based in New York City, announced a potential merger. However, talks broke down abruptly when New York City-based Mount Sinai Medical Center offered Continuum Health a competing offer a few weeks later. No matter which organization Continuum Health chooses to partner with, it will form one of the largest healthcare organizations in New York City.

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In August, Milwaukee-based Aurora Health Care and Franklin, Tenn.-based IASIS Healthcare announced a partnership, which includes clinical affiliations and the formation of a joint venture — Aurora IASIS Health Partners. Englewood, Colo.-based Catholic Health Initiatives and Vancouver, Wash.-based PeaceHealth signed a nonbinding letter of intent to create a regional healthcare system in August as well.

In September, Yale-New Haven (Conn.) Hospital acquired the assets of Hospital of Saint Raphael in New Haven, which culminated more than a year of planning and regulatory approvals, and Boston-based Steward Health Care System completed the acquisition of New England Sinai Hospital in Stoughton, Mass.

10. Heightened antitrust regulation and interference. As more hospitals and health systems continued to affiliate or merge in 2012, the Federal Trade Commission dug in its heels and kept close watch for potential antitrust concerns. In March, FTC Chairman Jon Leibowitz said challenging hospital mergers was one way for the agency to control healthcare costs by preventing oversaturated markets and higher prices. However, the FTC's aggressive and pronounced stance toward hospital mergers and acquisitions has befuddled some healthcare providers. Many say the healthcare reform law promotes collaboration and consolidation, as these relationships can lead to better cost efficiency, and the FTC is working against the law.

The past year brought two major antitrust cases between hospitals and the FTC, both of which serve as interesting case studies for future hospital consolidation in a highly regulated environment. In April, the FTC ordered Toledo, Ohio-based ProMedica Health System to divest St. Luke's Hospital in Maumee, Ohio, ruling that the merger would lessen competition in the area and would likely result in higher prices. ProMedica and St. Luke's announced in April that they plan to appeal the FTC's decision.

The second major dispute involves Phoebe Putney Health System's acquisition of Palmyra Medical Center, both located in Albany, Ga. The FTC filed suit in April 2011 to block Phoebe Putney's acquisition, which was structured through an arranged $1-per-year lease with the system's owner, Hospital Authority of Albany-Dougherty County. The FTC claimed the transaction would create a monopoly in the region, raising prices for healthcare services while reducing competition. A federal judge sided with Phoebe Putney in June 2011, and an appeals court upheld that decision in December. The case is now headed for the Supreme Court.

11. Stage 2 final rule for meaningful use released. At the end of August, CMS released the final rule for stage 2 of the Medicare and Medicaid Electronic Health Record Incentive Programs. Starting in 2014, hospitals and healthcare providers must attest to the requirements to qualify for incentive payments under the program.

The structure of the core and menu objectives for stage 2 is similar to stage 1. The biggest difference is the focus. Stage 1 set basic functionalities hospital EHRs must have, such as capturing data electronically and providing patients with electronic copies of health information. Stage 2 emphasizes health information exchange between providers and promotes patient engagement by requiring providers to give patients secure online access to their health information. According to HHS Secretary Kathleen Sebelius, these changes intend to lead the healthcare industry to more coordinated patient care, reduced medical errors and greater patient engagement.

In stage 2, hospitals and providers must provide 5 percent of patients with online access to health information as well as secure messaging between patients and providers. CMS hopes these new objectives will encourage patient engagement. Hospitals and providers must also send a summary of care record for 50 percent of transitions of care and referrals to another provider, as well as electronically submit a summary of care for more than 10 percent of transitions of care and referrals. This summary of care must be sent to a provider with EHR technology designed by a different EHR vendor. These requirements intend to spur commitment to electronic exchange.

Other differences in stage 2 compared to stage 1 include a process by which providers may submit clinical quality measures electronically, reducing the associated burden of reporting on quality measures. A payment adjustment exception was also added for specialty physicians in anesthesiology, radiology and pathology.

Overall, response to the final rule has generally been positive, but some of the organizations that submitted comments on the proposed requirements, such as the American Hospital Association, are still concerned. The AHA believes the final rule has set an unrealistic date — Oct. 1, 2014 — by which hospitals must achieve initial meaningful use requirements or incur a 1 percent penalty. The AHA also contends that CMS has complicated the reporting of clinical quality measures, creating new burdens for healthcare providers.

12. The beginning of meaningful use and HIPAA audits. In July, CMS announced it hired the accounting firm Figliozzi & Company of Garden City, N.Y., to audit Medicare providers and dual-eligible participants in Medicare and Medicaid that had received federal incentive payments for electronic health records. Those providers who will be audited will receive a letter and have two weeks to provide the proper documentation.

If audited, physicians and hospitals must provide four types of documentation to support meaningful use attestation: documentation from the Office of the National Coordinator for Health IT that shows the provider used a certified EHR system for MU attestation; information about the method used to report emergency department admissions; documentation that the provider has completed attestation for the core set of MU criteria; and documentation that the provider has completed attestation for the required number of MU objectives.

In June, HHS selected KPMG to conduct HIPAA audits on 150 covered entities before the end of 2012 as part of a pilot program. These audits will require a site visit, which will involve interviews with hospital leadership, an examination of hospital operations and observations of compliance with regulatory requirements. If a hospital is not selected for an audit under the pilot program before the end of December, they may still be subject to future HIPAA audits under the expanded program, making it a matter of *when* not *if* hospitals may be selected for an audit. While HIT-related audits are just beginning to impact hospitals, they are yet another sign of the government's increased regulatory interest in hospitals and health systems across the nation. ■

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Becker's Hospital Review Annual CEO Strategy Roundtable: 11 Leaders Discuss the Changing Healthcare Environment

Becker's Hospital Review hosted its Hospital Strategy Roundtable Nov. 1 at the Ritz-Carlton Hotel in Chicago, bringing together 11 hospital industry leaders from across the country to discuss current challenges and opportunities facing the industry, how hospital strategy will need to change to survive and which strategies will provide a foundation for long-term success.

Participants

Larry Anderson, CEO, Tri-City Medical Center (Oceanside, Calif.)

David Brooks, CEO, Providence Regional Medical Center Everett (Wash.)

Teri Fontenot, President and CEO, Woman's Hospital (Baton Rouge, La.)

Larry Goldberg, President and CEO, Loyola University Health System (Maywood, Ill.)

Steve Goldstein, President and CEO, Strong Memorial Hospital (Rochester, N.Y.)

Dean Harrison, President and CEO, Northwestern Memorial HealthCare (Chicago)

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

Barbara Martin, President and CEO, Vista Health (Waukegan, Ill.)

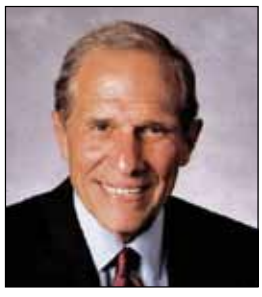
Megan Perry, President, Sentara Northern Virginia Medical Center (Woodbridge, Va.)

Jim Skogsbergh, President and CEO, Advocate Health Care (Oak Brook, Ill.)

Quint Studer, Founder, Studer Group

Moderators

Scott Becker, JD, CPA, Publisher, *Becker's Hospital Review,* **and partner, McGuireWoods**



Chuck Lauer, Former Publisher, *Modern Healthcare,* **Career Coach and Public Speaker**

The following is an excerpted transcript of the event's discussion.

Chuck Lauer: We're right in the front of a major change possibly — it will either be Barack Obama or Mitt Romney and depending on who you talk to, you're not quite sure what will happen. What impact do you think the election will have in terms of the industry and many of the programs that have been undertaken?

Steve Goldstein: I think this is one of the most important elections that we've seen in decades because it really does differentiate different positions. What will happen with the Affordable Care Act of 2010? What will be the foundation of Medicare and Medicaid? Will abortion be legalized throughout the United States or not? These are all issues that will play out.

I think one of the more important issues is that there are a lot of folks right now standing on the sidelines. If you look at what's happening with exchanges, if you look at what's happening with Medicaid, [it's] not clear yet that the 32 million people that have potential access for health insurance through the [ACA] will be able to achieve that. Many states, six states in particular, have said they will not offer exchanges. Fourteen have started putting them in place. Many are just dipping their toe in and waiting to see what happens with the election.

The same issue occurs in Medicaid. Not all states — in fact a number of states have indicated that they will not expand their Medicaid rolls. So I think who becomes president will make tremendous difference in how our delivery systems are shaped, whether or not sequestration and all of its consequences develop and, frankly, the potential of fee-for-service system over time. I think it's just an enormously important time.

Chuck Lauer: Teri Fontenot, one of the things you didn't mention is that you are the current chairman of the American Hospital Association. How do you react to what Steve has just said? Do you agree with him?

Teri Fontenot: Absolutely, I agree with what Steve says. Steve serves on the board of the AHA with me so we hear a lot of the same things. But if we take it to a less macro sense — I certainly agree that the delivery system and what happens with the Affordable Care Act is going to be very critical — but when you take it down to the hospital-level or hospital system-level and what we do every single day, there is not going to be as much of an impact.

We already are working very hard to be held more accountable. There's a lot of transparency. Certainly what Steve referred to as how people will be insured or covered, that has some impact, but what we do day to day operationally, I don't see that it has much of an impact, really, at all. We know that the current cost structure for care in our country is completely unsustainable.

Chuck Lauer: Bill Leaver, you're way up in Iowa. What's your take on where things are headed and what's happening?

Bill Leaver: Well I would agree with Teri. I think that what we're working on in the efforts around gearing up to do population health, care coordination — all those things are going to be meaningful whether or not Republicans gain control of the White House or Democrats retain control. I think delivery and payment reform will be here to stay.

We believe fee-for-service is going to be a thing of the past, and the accountable care organization financing in the current law is transitory to something different, which is most likely a bundled global payment. In our view, the real key is who is going to have control of that global payment. … I do think the issues around the Medicaid expansion and covering the uninsured will be impacted by who wins this election. I think if the balance power shifts, that will be rethought. But I think there is bipartisan support for payment and financing reform.

Larry Anderson: I don't disagree with what anyone said so far. But I do think that we have

Larry Anderson, Dave Brooks, Teri Fontenot, Larry Goldberg

to look at it from an employer standpoint. All hospitals are huge employers. We've done some analysis for just our hospital — we employ 2,400 people and we're insured using UnitedHealthcare as our platform for that and they're also our capitated partner. I have to say it drives the cost of our healthcare benefits for our employees up $10 million over the next six years. That's our estimate. We're not only talking about the uninsured in America, we're talking about everyone in America is impacted by this.

Chuck Lauer: Dean?

Dean Harrison: The only thing that I would add that hasn't been mentioned is one of the things we hope for, no matter what happens with the election, is to create more access for patients. There are a number of us involved in academic medical centers, and there is a lot being thrown around about future funding for graduate medical education. For those of us training the next generation of physicians, we have a lot of concern over where the money will come from to ensure that we're able to continue providing education to produce the physicians who will be available, especially primary care physicians, to take care of patients.

Chuck Lauer: I went to the National Center for Healthcare Leadership meeting last year. There was a discussion about ACOs. The thing that mystified me most of all was there were five CEOs on the panel and every one had a different definition for what an ACO was, and more importantly, how they were implemented. Do you have an ACO you're working with now [Megan Perry]?

Megan Perry: We do not. We've skipped the ACO and gone to the clinically integrated network.

Barbara Martin: We don't have one either, very purposefully. The system we're with [Community Health Systems] — it's kind of a wait-and-see game. We're all competitors, and Advocate has been very aggressive in ACOs. We look at independently integrating with physicians. They really are customers. Employing and working with integration with them, so we're looking at it more from a local market opposed to a large system.

David Brooks: We haven't developed an ACO directly. We have a health plan in Oregon, so we licensed a health plan to come up to our community, which is north of Seattle, and bring in a Medicare Advantage product. I think if we were to license that plan for commercial, we would become very threatening to the other commercial plans that we partner with. So we have been very careful about that.

Chuck Lauer: In the for-profit sector, many have said, 'We're not going to [form an ACO].' And I understand because they have stakeholders that say, 'If you do it, it's going to cost a lot of money.' Quint, what are you hearing?

Quint Studer: Inconsistency is what I'm hearing. In healthcare, I think the strategies are normally the right strategies for the region or community that the CEO is in. I think the structures are not where we run into problems. I continue to think the issue is execution.

Larry Anderson: We're a rather small hospital compared to most of the systems represented here. We put together an ACO that is now comprised of 160 doctors, 9,000 Medicare lives. It's a shared savings model. The comment that you have to be concerned about the costs of it is very valid, because we're keeping very close track of that. Not just the cost of starting it up, but the money that we're going to give up from a hospital standpoint to develop a shared savings model.

Bill Leaver, Barbara Martin

Jim Skogsbergh, Quint Studer

So, I don't think that's been fully thought out by the government, but we're doing it to gain a competitive advantage against competitors who are not in a position where they can create an ACO. We think it will provide us a drawing point for doctors to come because they can participate in shared savings. We started with 60 doctors. Now we're up to 160.

Scott Becker: How do you see the mix between how much effort is going into ACOs on the commercial side versus on the Medicare side?

Jim Skogsbergh: The genesis of our Advocate ACO was really in the commercial arena with Blue Cross [in 2010]. It's a shared savings arrangement. The short story is this: The old way of doing business just wasn't working, really for either party. We really said, 'Let's just create a new model,' because everything we were doing to improve efficiency hurt us financially because of the nature of the contract we had. All those benefits accrue to the insurer and that doesn't work for us.

We fundamentally believe if we focus on improving outcomes and lowering costs, we're going to survive whatever storm comes our way. Then we had infrastructure that allowed us to participate in the ACO when the legislation was passed. But ours really was born well before the legislation came out.

Scott Becker: How quickly do you transition compensation systems with physicians as you move through these different methods? Do you?

Jim Skogsbergh: I think eventually, you absolutely have to. Most of us would agree that when we talk about physician compensation systems, we all move carefully, very carefully, as we should. We need to be thoughtful about it. But our situation didn't call for drastic, massive changes — it's a shared savings contract, so in a sense, our physicians are billing fee-for-service medicine. We're going to compare our costs with the rest of the marketplace. What's the difference? Then we'll share it among ourselves and Blue Cross. It's worked fairly well for us so far.

Larry Goldberg: I praise everybody for doing a lot of experiments, but the reality is: How do we get from here to there? When I look at our organization, I think we're probably the best positioned to be an ACO except we don't have the scale. We don't know how to manage risk. We're a fully integrated faculty model. We have 28 ambulatory sites, 4 multi-specialty clinics. It's basically a mini Kaiser [Permanente] model all on one IT system. [It's] really well positioned to do bundled payments … except there are 80 hospitals in [the Chicago] metropolitan area. It's an incredibly fragmented market. Jim has done a wonderful thing to really get the market moving and thinking differently. When we talk to insurers, this is not just a provider game.

When Blue Cross has 70 percent of the marketplace and is really redirecting care, [it's a] conversation about … are we going to get cost out unless we [get individuals into some sort of] managed care in which you can manage care across the continuum? It makes it difficult when you're running on a 2 to 3 percent margin, particularly when you're academic and have other important things to invest in.

My mantra has been, 'Look, we're really good at this fee-for-service model and as much as all of this is happening, we're still in a fee-for-service market right now.' Everybody in our market is stealing doctors, trying to get market share. My message is...there is an overlap. Let's focus on fundamentals that exist in both markets: access, good quality metrics, getting our costs down and providing patient experience.

Megan Perry: Sentara has been a fully integrated system in the state of Virginia. We started our health plan back in the early 80s. We've been, in theory, managing risk for quite a long time. But we had to come to the cold reality to understand that we really haven't [managed risk]. … We've still worked in silos. We've spent the last few years trying to experiment with this, and we've had all the right components, yet we still haven't quite figured it out.

We have to change our whole corporate culture. We're still organized as hospitals. We have to take a good hard look — how are we organized and incentivized as executives? Right now, as a hospital executive, you want to fill your beds. So you have to think about how you're going to [restructure the system to] reward the behaviors you're going to want to see.

Bill Leaver: We also have an ACO. We've been very aggressive. We have shared savings arrange-

ments, both with Medicare and commercial, in seven of our nine markets. We view it as a transition to a different payment model, which really forced us to break down silos, think about how [to] integrate the care and focus attention on what is in the best interest of the patient. [We're] not necessarily focused on filling beds or physician offices….Here's the other point: [If] we don't do this, somebody else will, and we won't like the 'somebody else.' It'll be the insurance companies or someone else we're not even thinking about today.

Chuck Lauer: How have you changed in terms of how you view your day-to-day activities and how you run your hospitals?

Jim Skogsbergh: I think all of our jobs have probably changed in last decade. I've been at Advocate since 2001. Our focus is much more strategic now. We're trying to figure out where the puck is so [we] can skate to it. That notion of where is this industry going and how do you get ahead of it — that's occupied more of our time in the day-to-day. Susan Lopez is in the audience and she runs Advocate Illinois Masonic Medical Center [in Chicago], and we're glad she does. Our role is to support her as best we can and make sure the care delivered at Masonic is outstanding. And Susan does a great job, but I'm not managing Illinois Masonic Medical Center. I'm thinking about the future of our [healthcare system].

Chuck Lauer: Dean, you have one of the largest urban hospitals in the country. How has your life changed since you came in 15 years ago?

Dean Harrison: We've been fortunate in having a really strong patients-first culture, a really strong quality culture and [strong] execution culture. Those are great assets to have inside your organization. No matter what you're dealing with, those things guide the organization and your initiatives. I think a lot of us are spending much more time figuring out the right alignment strategies with physicians, with physicians who don't currently work with us that might want to work with us [and] providers in the marketplace.

We're looking at where we might add value and fundamentally asking questions of, 'If this really isn't adding value, why do I need to own this? Why am I not finding a partner?' We may be competitive in some areas, but in other areas, we should be doing things together. Especially for the academics in Chicago, [we should be] finding ways to say, 'There will be scarce resources for research going forward. Are there any opportunities we can work together for the benefit of society? We'll compete on clinical programs, but are there things we can do in the community together?' I think a lot of us are having conversations that five or 10 years ago we might not have had. We're saying, 'What is the right thing to do? What's fair? What will actually improve the overall health status of our community?'

Larry Goldberg: In some sense, I feel like we're incredibly well positioned. We have all our physicians aligned. We're all on the same compensation system. But I think there are four global issues that make all this so difficult, and they're macro issues. One is that everybody is making a lot of money — hospitals, doctors, insurance companies, drug companies, device companies. There is lots of lobbying and everybody is protecting their financial interests. Two: As a country, we can't have an adult conversation about rationing.

Thirdly, if you look at the healthcare industry over the last 15 years, it's the fastest growing sector of jobs. Now we could all get together and come up with some good plans to standardize what we do — a lot of the documentation work, for example. But where are those people going to work? In many communities, we're the biggest provider of jobs.

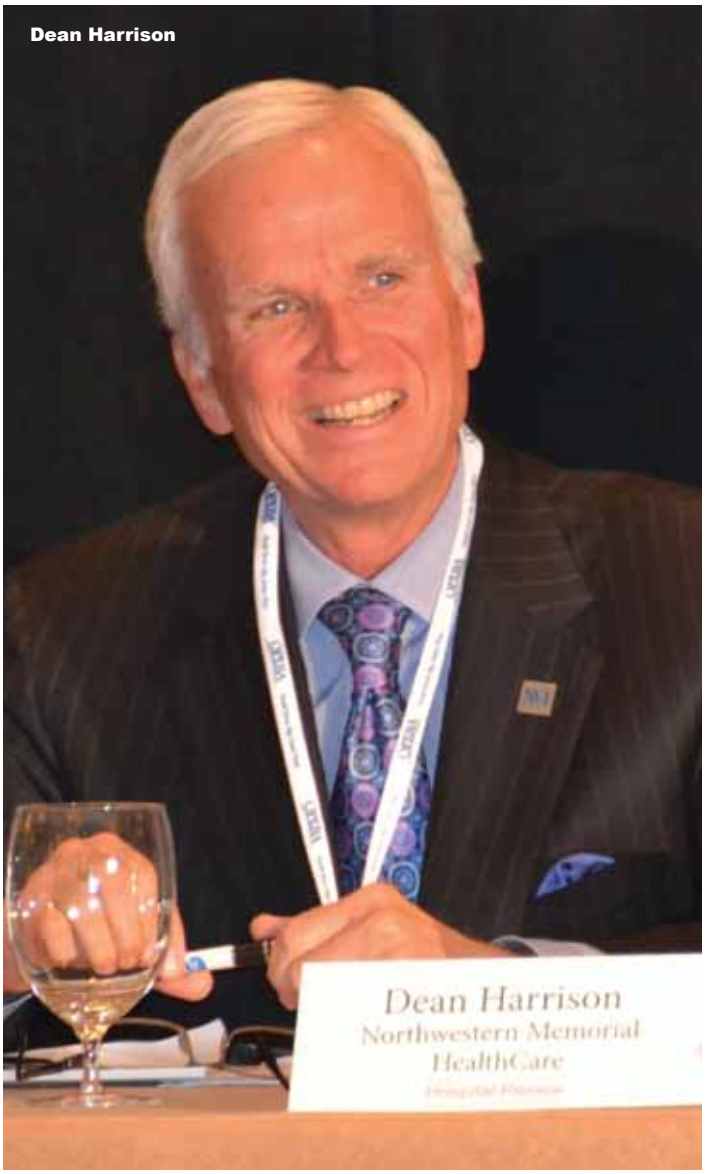
The last thing we struggle with as an academic medical center is that the NIH really funds [clinical research] for the world. All the basic science that becomes goods and services that industries across the world can benefit from are supported through our government and the research that happens in our facilities. These are underlying global questions. We're doing things that set us in the right direction, but those are really big social topics and issues that we're all dealing with.

Larry Anderson: For my hospital, right now we're in a very reactionary mode. From the moment the ACA was passed…we ran an initial model on the value-based purchasing component and decided we'd lose $800,000. That was a lot of money for us. We just got our first notification last week of what it'll cost us and it is $50,000 because we've gone to work on it.

I think all of us are working hard to understand the law and its ramifications for us, especially financially. But at the same time, we're working on quality because we see the end game: better medicine at a lower cost. We've now become 14th in the nation for heart attack readmission rates. We saw the issue of readmission rates being penalized and said we can't afford that.

David Brooks: I agree with what was said earlier. Jim nailed it in a lot of ways. It's still about internal execution. We have great teams that make it happen reliably. My role in the last couple of years — I spend so much more time on partnerships. I never talked about the "total cost of care" three years ago. But we now are working on it, trying to understand it, profile it and make improvements on that. I think that starts in the CEO role.

We look at overall community utilization now — of hospital beds, emergency room usage, skilled nursing, inpatient rehab and so on. We never focused on those things before. I think, at the leadership level, if we're going to serve the total members of our community, we need to profile at the macro level while ensuring phenomenal execution at the service level.



Barbara Martin: I think the key here is we all have different models. At the end of the day, what we have to survive on are relationships. We have to [build] strong relationships with physicians, whether they're employed, acquired or independent partners, and our patients and communities. And [we have to] produce those outcomes. We know CMS has outcomes for us. Our reimbursement is not going to get better — it's reality whoever wins [the presidential election].

I want physicians to only admit at my hospital, but the reality is I have competition, so you try to give as much loyalty and strive for great patient satisfaction and work with elected officials in the community who will support my initiatives and my strategic goals to help me get to the next level. I'm in a bit of a smaller system with a lot of competition from big systems, but that's okay. We have to produce outcomes.

Scott Becker: Some large multi-market systems are very closely connected. Then I see other systems where there is complete disconnect from the top of the system. How have you managed to handle that connection at the top to the local level? How do you make that work?

Bill Leaver: We're in our ninth region now in Quincy, Ill., and we try to make that connection by monthly [meetings with] regional CEOs. Their job is changing. They're no longer managing institutions. They're managing an organized system of care in their region. They're responsible for physician alignment in that market to manage population health. We try to create that connection by — in unification around that vision by monthly [meetings].


Larry Goldberg

We spend five to six hours a month just talking about strategy. What are we developing at a system level that you can deploy regionally? Here are the tools around physician alignment but you have to deploy those in a way that makes sense for you and your region. We have same incentive metrics that we're all trying to achieve. I get out to the affiliate or regional boards and management teams twice a year. So four times I'm in the region talking about strategy, what we want to achieve and the success we're having.

David Brooks: One of the advantages of multi-market is the diversity of the markets. Using the for-profit industry speak, "the portfolio." [Providence Health & Services has] hospitals from Alaska to Los Angeles to Oregon, Washington state and Montana. Our Oregon market has been a historical high-performer. It has three or four hospitals, a 20-year-old, 400,000-member health plan, 500 to 600 employed physicians. It's done spectacularly well in performance and economically it has been very stable.

Well, this year, Oregon is in big trouble because of some changes in Medicaid at the state level. But other parts of Providence right now are very high-performing. One of the advantages of multi-market [systems] is the diversity it creates. We're all in different states with different state Medicare plans and state commercial plans, and they are going to have different peaks and valleys. That's an advantage of scale more so than economies of scale and purchasing, etc.

Larry Goldberg: We're a member of [Novi, Mich.-based] Trinity Health, so we have 47 hospitals and with the merger with Catholic Health East it will be 82. I think there are three real advantages. Most hospitals are second and third in our markets. Most don't have the kind of competition we have in these large cities. You take a place like Loyola, we were a BB-rated organization. You put these assets together and now we're AA-rated. We have access to capital that we never would have. You get the economies of scale.

It's really wonderful to have a system that knows how to step in [for things like] revenue cycle management, supply chain management and corporate compliance — things that distract us as administrators. You get those advantages. The last piece is advocacy. We're with the second largest Catholic health system in the country, and we're at the table [in terms of discussions around policy making].

Barbara Martin: I'm part of Community Health Systems. We have 148 hospitals in 28 states. The key is we all have common metrics. We all know what our goals are. We're all in very different markets, and some markets do better by year. Illinois is not a great state for Medicaid reimbursement, but we have to work with it. You have to use the good of whatever system you're with. Again, I think to be successful as an independent system within a larger system, you have to define your identity and you have to produce those outcomes.

Chuck Lauer: We went through [similar physician integration] 18 years ago, remember? A lot of consolidation that fell apart as time went on. I'm wondering, do you think physicians will continue to want to become employees of hospitals?

Barbara Martin: We got away from employing physicians. Now we've all gotten back to the employment model. It's very, very hard for physicians to be independent. They're coming to us to work with us. We all have to be very careful within the employment model, because we can either lose a lot, break even or do well.

Chuck Lauer: Can you make money with physicians as employees? Does it help?

Barbara Martin: It certainly helps drive volume and outcomes because you can reward them based on outcomes.

Chuck Lauer: So when you hire physicians, is it for market power?

David Brooks: You need to do that. That's an aspect of it. But we have to change the way our systems perform. We have to reduce total cost of care and create higher performing systems. Whatever happens with the Affordable Care Act, [that's not going away]. We have Boeing in our market as the most dominant employer. We're going to see substantially reduced payments for care. Unless we change the way we organize care, unit cost management is only going to go so far.

Bringing physicians on and other clinicians on and partnerships help us accelerate how we create higher performing care systems. It's not the goal to bring on physicians as employees for control — it's to bring on physicians in more integrated way so we can reorganize the way we deliver care.

Teri Fontenot: I think there are a variety of reasons [for physician employment]. Sometimes it may be for market power or leveraging. When you employ physicians, then you can pay them very differently and also require them to not be on staff of competing hospitals. That's the only way you can do that — when they're employed. I think back in the 1990s, a lot of hospitals were employing physicians because that's what everybody else was doing and they were afraid they were going to be left out.

Your question about do I think physicians will go back to private practice? I do not. Right now, more than half of residents are female. They don't want to run a small business. It's much too complex. It's an economies of scale [challenge], similar to that of standalone, small hospitals. You can't afford the IT support and skill levels and that sort of thing.

What we see in our market is for most physicians, hospitals aren't asking physicians to be employed. [Physicians] are coming to us, asking to be employed. I can't recall the last time a physician joined our staff and set up an independent practice. Most want the quality of life they can get when they're employed by a hospital. Then they can only see patients. They don't have to worry about billing and computer systems and the latest regulations.

Megan Perry: We started employing physicians in 1995. I think it is how you treat them — as partners, not as employees. We made the mistake as a health system of saying, 'Ok, well they now have a paycheck. They're all going to do what we want them to do.' We made those mistakes, and physicians aren't [employees]. They are independent, autonomous, well-trained individuals and we have to treat them that way. We put them back into private practice models and started to treat them as partners, not employees. That's very key in how you approach these physician relationships. How do we create relationships so they are meaningful partners with us in all the work we're trying to do here? We've made mistakes and learned from those.

Quint Studer: What I've seen is healthcare organizations getting so much better at analytics and diagnoses. We just did a study with 17,000 leaders on this. We've found is that there is still a challenge because senior leaders see the environment so much better than the rest of the organization. Senior executives see the external environment as very difficult over the next five years, but 37 percent of frontline managers think their organization can stay the same if their processes stay the same. When I tell this to people, they all look at me in shock until we do the survey. I think the bottom line is to communicate to stakeholders. If we don't communicate consistently, we won't get there.

Last point is the reduction of variance. Looking at a place like Virginia Mason that can do a certain procedure for 20 percent less than another organization — it's not because they're smarter, it's because they're more consistent. They've driven variance out of the system. We've been reluctant to drive variance out of leadership. You can't drive it out of other components of your organization if you're too inconsistent in the C-Suite. When we ask the C-Suite, "How consistent is your leadership team," they'll rank it a five or six on a 10-point scale. Then we ask how good is your organization at employing best practices? [Those answers] correlate exactly.

Scott Becker: Going back to Chuck's question about a decade ago, it has evolved from the most productive physicians being hired to broad physician groups being hired. How much concern do you have about the carrying costs of your employed physician organizations?

Jim Skogsbergh: We employ about 1,000 physicians, so we made a huge investment in the employment model. Having said that, three quarters of our panel for our shared savings contracts are independent, practicing physicians. We have between 3,000 to 4,000 physicians who are independent, practice physicians and about a thousand who are employed. The message there is I don't think one size fits all. We think different models can work. The trick is how you find that alignment.

We're bullish on employing physicians and that will continue, yet in our market, it's not right for everyone, and we think that's okay as well. Then your question about [the carrying costs of employment] — yeah, we worry about that a lot. The carrying costs of employing 1,000 physicians? Absolutely we're worried about it, but we monitor it all the time.


Steve Goldstein

Scott Becker: In what markets do you see the physician shortage becoming more critical? How big of a concern is it for more rural markets?

Bill Leaver: I think that will be a challenge in our market, but I see that as an opportunity. When you have a shortage, you then, by necessity, have to think about doing things differently. How do you care for people differently? How can I use extenders differently? I think actually that gives us, particularly in our Iowa markets, an advantage because we can drive change much more quickly.

Larry Anderson: In California, we have the ban on corporate practice of medicine. Not everyone employs physicians. Our hospital doesn't employ physicians. In my view, access to care under the Affordable Care Act is the single biggest issue we're facing. I'm very concerned about it. In California, we'll add 6 million [people to health insurance]. If that's accurate, that will flood the system. We don't have physicians capable of handling that. As Medicare and Medicaid are reduced, you'll have more physicians leaving the system. I'm not sure that's true all over the country, but it is true in parts of California and in my community.

Teri Fontenot: I think absolutely there is a shortage of physicians based on the current delivery model. If we can use extenders and forget about the traditional role of the physician, when nurse practitioners can do a great job, and [we utilize] the benefits of telemedicine — I see a lot of opportunities.


Megan Perry

One of the things in the Affordable Care Act that is the most glaringly absent is there is really no patient accountability. Advanced illness management, advanced directives — some people think that's rationing, but I don't. I think that's individual empowerment. If we can get Americans, whether they have health insurance or not, to manage their health and manage their conditions, they don't necessarily need hospitals and physicians to do that the way we do it currently.

Larry Goldberg: I do want to point out where I want to go. We're an employed model with everybody on RVU compensation. We're talking about doctors and trying to go to integrated programs. The cultural change of medicine, of working in teams, we talk a lot about it but we're trying to change the compensation system so we are incentivizing programs. When you take our transplant program, we're not just doing RVUs. It's [about] outcomes, mortality rates and quality outcomes.

A lot of these shortages — a lot of these areas that don't have access to care [and have telemedicine programs] — it's really thinking programmatically. A lot of that, if we're honest, is marketing. It's not truly an integrated program with allied medical professionals really doing case reviews. This private practice model, it has to evolve until physicians work in systems of care. I do think this next generation [of physicians] will be different. They have to communicate more.

Chuck Lauer: In five years, where do you see this industry? What will change?

Larry Goldberg: I think every market will evolve at a different pace, but I'm hoping some of the big things are going to evolve. I really have a lot of hope for HIT. We've lived through this period where we have four or five now with stable platforms. Maybe there is something in that data and ability to manage evidence-based care that will come out and I hope will drive this.

Megan Perry: I think we're going to have new types of competition that will force us to think differently, especially around IT platforms. They'll change our worlds in ways we can only imagine. We're starting to see it a bit with virtual visits and telemedicine, but I think we'll see some competition in the IT arena that will change things we can't even think of right now.

Larry Anderson: What healthcare looks like five years out? I think higher quality and lower costs, absolutely. There is no other option. Anyone who can't get there isn't going to exist.

Megan Perry: Right now we get rewarded for market share. When that changes, I don't know if we'll need all the beds we have.

Quint Studer: The thing with the hospital beds is we have to remember our aging population. We'll need those extra beds. That's why flow is so valuable right now. We might need some of those beds with an aging population that some will need hospitalization. I've seen too many futurists look at the baby boomer population and say, '[The need for fewer beds] might not actually be true.'

Teri Fontenot: Consider all the people in hospitals today just because their chronic conditions weren't well managed. It may be we need the same number of beds, but people in the beds will be very different if we teach people about advanced illness management and how to manage their chronic illnesses at home. When we mix it all together, it's really hard to predict what it is going to look like. There are also geographic elements.

David Brooks: And what's the definition of a hospital? [Is it a] 24-hour hospital bed? That's the way we were trained, but I don't know if that will

be the definition of a hospital, especially as you move into rural communities or even parts of urban communities. I think we need to broaden what we think of as a hospital.

Dean Harrison: You asked the question how will things be different five years from now, but it's happening right now. It's always amazing how we think trends emerge one day, but then when we look back and go, 'This has been going on for some time.' I think five years from now, the trend that will be very visible to us is we'll be consumer-facing instead of provider-facing. We will be managing our institutions to provide care when, where and how patients want to experience it.

Right now, we deliver care when we want to and where we want to deliver that care. We direct patients to do certain things. Everything we're seeing is the emergence of an empowered consumer making decisions. Five years from now, we'll say, 'Oh yeah, this has been going on for some time.'

Barbara Martin: I think there is opportunity for any system. When we joined CHS six and a half years ago, in Lake County, they thought I was crazy. We needed access to capital. Today, [nearly] every independent hospital is becoming part of a larger system. That's opportunity to [join] big systems. Telemedicine, access to primary care — [big systems] can provide that.

Chuck Lauer: Consolidation is going on all over the country. The government is a bit concerned about all the consolidation because they think it's not fair and that systems may drive out other hospitals. Is it a good thing? Should it change?

Teri Fontenot: I think consolidations are good if they're done for the right reasons. It's not just about having market power and trying to control pricing. That's what the government doesn't like. But it you're coming together for economies of scale, to have a broader network and better coverage for care and access, that's the reason why consolidations are appropriate.

Scott Becker: I've heard a good deal from David and Larry about markets expanding. Dean, Jim and Steve — can you survive as big systems or do you have to be diversified?

Steve Goldstein: It depends who you are. In our case we're an academic medical center. In our case, we have to extend ourselves to about 2 million people at about 120 different sites. And we have to align ourselves with institutions [that offer] high-quality care at low cost. We offer population management products. We can do it by admitting those patients to other places from a high-cost center. It's really about creating alliances to achieve what you want to achieve, and in our case it's around population management. It's really about how you want to organize for the challenges you have.

Dean Harrison: For us, it's thinking about the system of care — the right care in the right place. Also, for serving our missions and thinking about those distinctive destination programs that might only be available in academic medical centers with the type infrastructure we have. Increasingly, it's not just serving the community around us in the region. We're playing on a national stage, and increasingly in cities like Chicago, we're playing on a global stage. Chicago is a pretty great platform and we have great healthcare in Chicago.

Scott Becker: Do you see more development of marketing like Cleveland Clinic has done for University of Chicago?

Dean Harrison: Absolutely. Whether in larger systems or based out of academic medical centers, absolutely. People are going to shop and have the information and go to where they think they'll have the best care.

Steve Goldstein: It's not just national. I do think international is really — we're in an aggressive mode. A lot of countries are calling on academic medical centers in figuring out how to bring jobs to America. That's one of our goals each year to do that. It's complex, but the world is a smaller place.

Jim Skogsbergh: Our board is studying that question now — do you need to move and diversify beyond the state? We're looking at it very carefully.

Chuck Lauer: Why did you get into healthcare? Give me a very concise reason.

Bill Leaver: Really, two things. One, I was raised to go out and do good things. Healthcare is a great opportunity to do that. And I love politics. And what better industry for those two things?

Dean Harrison: I love it. It was the only job I could find and it paid. *[Laughter.]*

Dean Harrison, Bill Leaver, Barbara Martin

Steve Goldstein: It's a complex field involving every aspect of society. We're in the heart of our communities and it's a great place to be. I've been at this a while, and it just keeps getting more exciting and more interesting. What more could you want from a career?

Quint Studer: Everybody I know in healthcare — I don't think we pick it, I think it picks us. I think it's a real DNA-calling.

Jim Skogsbergh: Honestly, I stumbled into it. I thought I was going to teach and coach and I ended up in healthcare. Why? My mom's a nurse — tremendous influence there. I'm unbelievably blessed to be working in this industry. It's the greatest industry in the world.

Megan Perry: I have ADD. So it works out great because I'm never bored and [healthcare] keeps me stimulated. It's a blessing to always be excited every day with something new.

Barbara Martin: Many of us came from a clinical background, working our way from hospital operations to administration. It's a passion that we have. It has a lot of stress and long hours. I think you have to have that desire and work ethic and passion to produce those outcomes.

Larry Goldberg: Professional basketball didn't work out. *[Laughter.]* I think it's a mission. I want to make a difference. I've had the opportunity of working for three great organizations that are very mission-focused.

Teri Fontenot: I wanted to be a tax attorney. I shifted to healthcare when I was the director of accounting at a local hospital. I've stayed in healthcare for two reasons. It's very mission-focused. The second reason is, personally, I love challenge and change.

David Brooks: What a great combination of personal challenge and community service.

Larry Anderson: It's the challenge and the mission. The challenge is probably equal to the mission. I think it was Warren Buffet who said being a hospital CEO is probably the toughest job in America. ■

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Managing the Transition to Value-Based Reimbursement: 8 Core Strategies to Mind the Gap (continued from page 1)

Some hospitals and health systems have opted to be first movers — they became a pioneer accountable care organization or developed a new program with a commercial payor — while others are taking a more cautious approach, focusing on building relationships with physicians and community organizations. Here, healthcare experts from across the industry share their experience with "life in the gap" and how hospitals and healthcare systems can prepare for reform while remaining solvent.

The challenge: Living in two worlds at once

Whether a hospital or health system chooses the first mover or second mover approach, it will face risks. By experimenting with new payment models first, a hospital can lose revenue in the short term because outside of select pilots, CMS is still reimbursing based on the fee-for-service system. By waiting, hospitals lose the opportunity of practicing the new skills and processes that will be needed to succeed in the future, which may cost them long-term revenue.

Baltimore-based GBMC HealthCare opted to be a first mover. In July, CMS approved GBMC HealthCare's Medicare Shared Savings Program ACO called the Greater Baltimore Health Alliance. This Medicare Shared Savings Program ACO is the only one in Maryland with a hospital component. GBMC HealthCare is also increasing the number of primary care access points throughout its system.

"We joke that we could do the right thing right into extinction, because if we cut unnecessary utilization of health services and lose that revenue while we are providing coordination that is not reimbursed, that is a huge problem for us," says John Chessare, MD, president and CEO of GBMC HealthCare. "My number one fear is this: that we redesign a much better system but the payment system continues to incentivize uncoordinated, ineffective and extremely expensive care."

Navigating the transition: Strategic options

There are many strategies for navigating the transition from a volume- to value-based healthcare system, and the success of each one will depend on individual hospitals' and health systems' cultures and markets.

1. Drive out waste.

One option is to focus on optimizing efficiency to eliminate duplication and save costs. "We are redoubling our efforts on performance improvement within our hospital, using Lean tools to try to drive waste out of the hospital, then free resources to apply to the building of patient-centered medical homes," Dr. Chessare says.

In fact, he suggests hospitals that do not think they have the funds to support reform efforts focus on streamlining care to shift resources to where they are needed most. "Hospitals that said they don't have money to do this should do what we're doing: Roll up their sleeves and drive waste out of their own processes, and they will find the resources," he says.

KentuckyOne Health, a non-profit system formed by Jewish Hospital & St. Mary's HealthCare in Louisville and Saint Joseph Health System in Lexington in January, is also working to eliminate redundancies in its transition from volume- to value-based care. Englewood, Colo.-based Catholic Health Initiatives, which has majority ownership in the system, aims to reduce expenses by $2 billion over the next five years to better operate in a reform environment, according to Dan Varga, MD, chief physician executive of KentuckyOne.

"That's a lot of expense to take out, and we're not able to do that just by optimizing labor metrics and optimizing cost of supplies in inpatient settings. We have to figure out how to take care of inpatients in lower cost settings," he says. He says KentuckyOne will have to look to comprehensive outpatient settings, home care and various other settings to manage patients more cost effectively while improving quality.

2. Implement new payment models.

One of the more common strategies of transitioning to healthcare reform is participating in new payment systems under CMS pilots, such as Pioneer ACOs, or with private companies, such as Cigna, which aims to establish 100 accountable care initiatives by 2014.

In 2010, San Francisco-based Dignity Health formed an ACO with Blue Shield of California and Hill Physicians to serve members of the California Public Employees' Retirement System. So far, the ACO has saved more than $37 million and reduced inpatient readmissions and the average length of stay, according to Michael Blaszyk, senior executive vice president and CFO of Dignity Health.

"Our ACO collaboration has led and should continue to lead to population management capabilities that should enable us to increase our capacity to serve additional populations [and] increase revenues while providing a forum to work with our physicians and other partners to reduce costs and improve quality," he says.

There are other options for hospitals and health systems to incentivize efficient, high-quality care in addition to ACOs. For example, while GBMC HealthCare participates in an ACO, it is also rolling out a financial incentive program that will give employees bonuses if they meet clinical and financial goals. "In the first year of our three-year strategic plan, we did pretty well and we made a lot of changes, but my concern was that not all of the family was in the improvement boat," Dr. Chessare says. "We decided to test the notion that if we put a financial incentive out there, we might get more people hungry to make changes to help us get closer to our vision."

3. Collaborate with other healthcare providers.

Another strategy for managing the period of transition from fee-for-service to pay-for-performance is collaborating with other healthcare providers, including physician practices, rehab facilities and ambulatory centers. Reaching out beyond the hospital space will be crucial for hospitals going forward, as they will likely be responsible for the patient's continuum of care, not just the patient's hospital care.

8 Core Strategies to Mind the Gap

1. Drive out waste.
2. Implement new payment models.
3. Collaborate with other healthcare providers.
4. Invest in primary care.
5. Develop health data analytics.
6. Establish employee health programs.
7. Begin a cultural revolution.
8. Evaluate and re-evaluate strategy.

"We believe that our ability to manage this transition is optimal when we are effectively engaged with our physicians, patients and payors," Mr. Blaszyk says. "The industry must improve communication among providers, payors and physicians in order to meet the demands of a reformed healthcare environment."

Partnering with physicians is particularly important for hospitals as healthcare reform changes demand a coordinated approach to care. "As we look to redesign the delivery system for the future, it is very important to have physicians and other clinicians in leadership roles," says Valinda Rutledge, president of Jewish Hospital in Louisville, Ky., and leader of parent company KentuckyOne Health's Louisville market. "They're the only people who understand how that redesign has to happen."

Hospitals can partner with physicians to standardize patient care processes to improve quality, increase efficiency and lower costs. Standardization will help hospitals prepare for healthcare reform measures that reward high quality while allowing the hospital to continue to prosper under the current fee-for-service system, which rewards productivity.

Partner with past competitors

Hospitals struggling to prepare for healthcare reform in the current, non-reform environment may also consider partnering with past competitors, such as other hospitals in the region, to combine resources, eliminate waste and gain more clout with payors. Mr. Blaszyk suggests hospitals "explore creative, even unconventional, ways to partner with others in order to achieve better operational effectiveness that promotes patient satisfaction."

4. Invest in primary care.

Some first movers in the transition to healthcare reform have invested in primary care and patient-centered medical homes to better track patients through the continuum of care. As hospitals still face decreased reimbursement, however, these investments may need to be scaled back depending on the hospital's financial resources. "Last year we spent a lot of money building a lot of new primary care sites," says Dr. Chessare. "This year we pulled back a little on the throttle and slowed down building primary care sites because, quite frankly, we didn't have the margin to do it."

When new payment systems take effect, these primary care sites will be a key strategy to coordinating care and managing population health. "Right now a lot of hospital services that are being used are the end results of poor coordination of care," Dr. Chessare says. By improving coordination of care through primary care partnerships and integrated health information systems, hospitals can prevent unnecessary readmissions and unnecessary utilization.

5. Develop health data analytics.

Healthcare analytics will play a significant role in the delivery of care in the future as hospitals learn to use trends in patient data to drive new strategies and decision-making. Investing in health IT and analytics now can help hospitals learn the skills required to measure, track, analyze and apply data to real patient care. While health IT requires a significant investment now, it will be crucial for determining whether a hospital meets the financial and quality metrics it will be paid for in the future.

Ms. Rutledge says there are three components of analytics that hospitals need to develop. The first is a database that includes data for patients beyond the four walls of the hospital — such as data on primary care visits, rehab facility visits and nursing home stays. The second is the development of competencies to interpret the data. The third is redesigning care from the analytics so multidisciplinary care teams can provide comprehensive, coordinated services to patients.

6. Establish employee health programs.

Second movers — hospitals and health systems that are hesitant to implement system-wide changes — can start preparing for new payment models by starting with their own employees.

"The logical place to start, the place where there's limited risk but a lot of upside, is with employees," says Bill Woodson, senior vice president at healthcare analytics company Sg2. "Most [hospitals] are self-insured, it's a risk they already own. If they implement care management models and improve quality, they can benefit from that and then take it out to the marketplace."

For example, hospitals can lower insurance costs for employees who perform certain wellness activities, such as going to a wellness center or having a nutrition consultation. Experimenting with population health management strategies for their own employees allows hospitals to work toward transforming the delivery of care with very little risk.

7. Begin a cultural revolution.

The gap between the current and future reimbursement system provides an opportunity to start changing the hospital's culture to focus more on the whole patient and wellness instead of single episodes of care and sickness. Changing the culture of an organization takes time; starting now can help prepare hospitals for the future. "The challenge is not only financial, but cultural in terms of changing the [organizational] mindset of the healthcare industry," Mr. Blaszyk says.

By assessing the hospital's current culture and communicating with physicians and staff about healthcare reform changes, hospitals can determine how fast the organization is prepared to move to these new models of care. "How good is your clinical leadership overall, and what's your internal appetite for innovation and risk?" Mr. Woodson asks. "Are you willing to struggle to get to the next level? Do you have an incentive structure in place internally with leaders and employees and physicians to pull all this off?"

8. Evaluate and re-evaluate strategy.

This period of change from fee-for-service to pay-for-performance is a time of uncertainty and constant change. Hospitals therefore need to constantly evaluate their strategy and determine if the strategy needs to change to better meet the organization's goals.

"We look at strategy almost on a daily basis," Dr. Chessare says. "We have a set of organization-wide goals that are the answer to the question 'How will we know if the changes are leading us to our vision?'" GBMC HealthCare's goals align closely with those of healthcare reform — better health, better care and lower costs — and specific outcomes such as patient satisfaction scores and operating margin indicate whether the system's strategy is helping meet those goals.

Implementing strategies for healthcare reform goals now does not prevent the system from operating successfully in the current environment, and may even aid in successful operation, according to Dr. Chessare. "There isn't anything in our strategy that is bad. We're making the kind of care system we would want for our loved ones. Even in a fee-for-service world, we're going to be attracting more patients to our company."

Deciding when to take the leap

The number and kind of strategies hospitals adopt will depend on how fast they want to move to the new payment model. To determine what level of risk to take, hospitals need to be aware of their market — what the prices of their competitors are, what the payors in the area are doing and how consumers are behaving, according to Mr. Woodson. "Be on the ground; understand what's going on with your competitors, your payors. Be able to move quickly if you need to," he says.

Ms. Rutledge also emphasizes the importance of knowing one's market. "You want to be the first mover, but not faster than the market can support," she says. As markets differ across the country, so does the speed of change among hospitals. Massachusetts hospitals, for example, have been first movers because some health reform measures had already been enacted in the state.

Ms. Rutledge suggests four strategies to innovate within the boundaries of the market. First, she recommends engaging and educating the board and community leaders about reform so everyone is prepared for the coming changes. Second, hospitals should learn from others nationally to identify strategies that may work in one's own market. Third, hospitals need to stay focused. "If you're all over the board trying to do 20 different initiatives, you're not going to do anything well. Figure out the core competencies of the organization and figure out which project gives you those competencies," Ms. Rutledge says. Last, hospitals need to determine best practices in their organization and decrease variation from those best practices.

As hospitals and health systems continue to navigate the transition between two different healthcare environments, healthcare leaders will need to seek ways to manage current margins while preparing for more quality-based payment systems. Being aware of the market and the culture of the organization can help hospitals achieve this balance. ■

Pension Management Predicaments? 3 Dominant Hospital Pension Strategies **(continued from page 1)**

For example, Mr. Gamzon worked with a hospital client on a monthly pension obligation report this past July. In one month, the large hospital lost $60 million on its balance sheet. That is not a final figure for the hospital and only a month-long snapshot, but it showed the magnitude of the problem.

"Picture yourself as a hospital CFO who is trying to manage everything else — the Affordable Care Act, other issues around healthcare reform — and here, out of the blue, an actuary says, 'By the way, you don't have to file this right now, but you just lost $60 million on something that you have no control over whatsoever,'" Mr. Gamzon says. "You have no control over interest rates. If that had been a fiscal year ending July 31, that would have been a $60 million loss."

When a hospital's pension liabilities and debt obligations become too high, its credit rating suffers, too. That's why hospital CFOs and executive management teams are looking at new strategies.

"Even though employers made those types of statements a year ago, the interest rates have fallen so much and unfunded liabilities are so high at this point that there is no sign in the future we're going to get a meaningful improvement," Mr. Gamzon says. "Now, hospitals are willing to do things now they weren't willing to consider a year ago."

"That's why CFOs basically have said, 'I understand the value of traditional [defined benefit] pension plans — it's good for retention, and it's an important part of our recruitment — but what does it matter if I don't have a hospital?'" Mr. Gamzon added. "What if I can't go into market and borrow money?"

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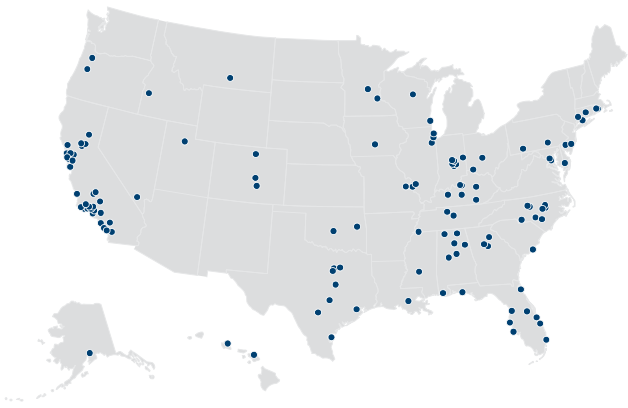

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In light of the volatile U.S. economy and growing concern over how to manage pensions, here are three dominant pension strategies that hospitals and health systems, in particular, are gravitating toward.

1. Freeze the defined benefit plan and move to a defined contribution plan. There are two main types of retirement programs: defined contribution and defined benefit plans. DC plans are those in which hospitals contribute money to the employees' accounts, but the employees assume the investment risk and reward (403(b) plans and 401(k) plans are common types of defined contribution plans). DB plans — which traditional pensions fall under — are those in which a benefit is promised at a future date, and the hospital is responsible for both contributing and investing the funds. However, bad investments do not impact the benefits provided to plan participants.

Lisa Goldstein, an associate managing director at Moody's Investors Service and an author of several reports on non-profit hospitals, says roughly 68 percent of the agency's rated non-profit hospitals still maintain DB plans. That number is on the decline, though. She says the top overall pension strategy that hospital and health systems are employing right now is to freeze the DB plan and move to a DC plan.

"Hospitals can say all new employees as of a certain date will go into DC plans, or they can freeze current DB plans and put everyone into DC," Ms. Goldstein says.

Tim Jodway, CFO of Garden City (Mich.) Hospital, can attest to that trend, as the 323-bed, 1,000-employee hospital froze its DB plans several years ago. "'Our [DB] plans have been frozen for at least five years, but it still requires funding every year, so that is a cash drain," Mr. Jodway says. "But going forward, we have a DC plan. That's our main vehicle."

A recent study from the American Hospital Association and retirement plan firm Diversified also showed that DC plans at hospitals are at a 10-year high. Roughly 73 percent of employees that work at hospitals or health systems participate in a 403(b) DC plan, the highest level in the past decade. The survey, which looked at 180 hospitals and health systems, also found that most hospitals that still offer DB plans have frozen the plans to either new employees or all employees.

The primary reason hospitals are freezing DB plans is because interest rates in the markets have been historically low, as Mr. Gamzon mentioned. Low interest rates coupled with overall investment losses are spelling panic since hospitals are obligated to pay DB employees their pensions regardless of the hospitals' own financial instability.

"I think what has really affected hospitals and health systems this past year is the decline in interest rates," says Jim Grigg, CPA, partner and national healthcare assurance practice leader at Crowe Horwath LLP. "Actuaries are determining the accumulated value of future benefits, and an important driver in this calculation is the discount rate assumption. This actuarially determined liability increases as the discount rate — interest rate — declines. That resulted in many hospitals taking a significant charge to earnings or net assets in the case of a non-profit hospital.

"That's the biggest issue with DB pension plans," Mr. Grigg adds. "They are so unpredictable as to the effect each year on financial performance because of the uncertainty related to interest rates and returns on investments. If you're a hospital with a DB plan, your credit rating is probably going to be adversely affected."

2. Fund more than what's required. Although DB plans are turning into a wardrobe few want to wear, several hospitals and health systems still have DB plans. "Nobody is really starting DB plans now," admits Martin Arrick, managing director at Standard & Poor's Ratings Services. "However, if you have DB plans, a lot of folks aren't giving up on them. They can keep them around, but it's tricky."

For example, in May, Moody's affirmed the Aa2 credit rating of Boston Children's Hospital, saying its DB plans are "relatively well-funded" with only $30.9 million in unfunded pension liabilities at the end of fiscal year 2011. Duke University Health System in Durham, N.C., also has been cited as having a very stable and manageable DB plan, according to Moody's.

What's the secret to DB pension success? Ms. Goldstein says there is no silver bullet, but larger organizations with more capital and liquidity that can afford to increase their annual pension contributions usually are able to keep a strong DB plan around.

"There's no magic potion to fund a pension," Ms. Goldstein says. "We engage management to look at long-term strategies to begin finding a reasonable way to fund pension liabilities. Some hospitals are funding above their required level to get ahead and to help manage those long-term liabilities."

3. Consider alternative pension structures. DB and DC pension plans grab a lion's share of the attention, but hospitals do not have to box themselves into those corners.

Mr. Gamzon says there are two other lesser-known pension plans that hospitals could potentially consider: cash balance and Pension Preservation Plus. Cash balance plans are a hybrid between DB and DC plans. The hospital takes the responsibility and risk for managing investments and guarantees the employee a fixed interest credit like a DB plan, but many of the other risks remain with the employee like a DC plan. Pension Preservation Plus, a program developed by PwC, is similar to a cash balance plan in that there are annual pay credits and fixed interest credits. However, the interest credits go into a DC plan as a discretionary employer contribution and are managed by the employee.

Mr. Gamzon says cash balance plans have both the pay credits and interest credits of a DB plan with all the investment risk on the hospital, but in PPP, the investment risks are shared.

Regardless of what route a hospital or health system takes with its pension plan structure, the executive team must do one thing above all else: communicate clearly to those who are affected most. Staff members, nurses and all other hospital employees depend on pension plans for their retirement. When changes to pensions are made, it can be a sensitive matter. However, receiving input from all stakeholders and being receptive to multiple perspectives will help hospital executives make the right pension decisions for their individual organizations.

"There's a lot of communication that goes on between management and employees regarding pensions," Ms. Goldstein says. "This is not an email blast. There should be face-to-face town hall meetings so management and [human resources] can explain what's going to happen, how it works and the rationale. A lot of communication is very effective." ■

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200 Hospital Benchmarks

By Molly Gamble

Comparative data is remarkably valuable in healthcare, as hospitals strive to master quality outcomes and deliver an experience that meets patients' expectations while remaining fiscally sound. *Becker's Hospital Review* has collected 200 benchmarks related to each of these demands from various healthcare organizations for hospitals to measure their performance and better assess their strengths and weaknesses.

Quality of care

30-day readmissions and mortality[1]

The following data is based on metrics included in the Hospital Consumer Assessment of Healthcare Providers and Systems.

1. Heart attack mortality rate
(Based on 4,351 hospitals)
25th percentile: 14.50
Median: 15.40
Average: 15.45
75th percentile: 16.40

2. Heart attack readmission rate
(Based on 4,287 hospitals)
25th percentile: 18.70
Median: 19.60
Average: 19.71
75th percentile: 20.60

3. Heart failure mortality rate
(Based on 4,494 hospitals)
25th percentile: 10.70
Median: 11.60
Average: 11.65
75th percentile: 12.60

4. Heart failure readmission rate
(Based on 4,493 hospitals)
25th percentile: 23.50
Median: 24.60
Average: 24.78
75th percentile: 25.90

5. Pneumonia 30-day mortality rate
(Based on 4,505 hospitals)
25th percentile: 10.90
Median: 11.90
Average: 12.10
75th percentile: 13.20

6. Pneumonia readmission rate
(Based on 4,510 hospitals)
25th percentile: 17.40
Median: 18.40
Average: 18.53
75th percentile: 19.50

Timeliness of care[2]

Figures reflect national averages.

7. Number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital: 60

8. Number of minutes before outpatients with chest pain or possible heart attack received an ECG: 8

9. Outpatients with chest pain or possible heart attack who received medication to break up blood clots within 30 minutes of arrival: 59 percent

10. Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival: 96 percent

Pneumonia patients who received initial antibiotics within six hours after arrival: 96 percent

11. Outpatients having surgery who received an antibiotic at the right time, within one hour before surgery: 96 percent

12. Surgery patients who received an antibiotic at the right time, within one hour before surgery, to help prevent infection: 98 percent

13. Surgery patients whose preventive antibiotics were stopped at the right time, within 24 hours after surgery: 97 percent

14. Patients who received treatment at the right time, within 24 hours before or after their surgery, to help prevent blood clots after certain types of procedures: 96 percent

15. Surgery patients whose urinary catheters were removed on the first or second day after surgery: 93 percent

Imaging[3]

Figures reflect national averages.

16. Outpatients with low back pain who underwent an MRI without trying recommended treatments first, such as physical therapy: 36.8 percent

17. Outpatients who had a follow-up mammogram or ultrasound within 45 days after a screening mammogram: 8.5 percent[4]

18. Outpatients who received cardiac imaging stress tests before low-risk outpatient surgery: 5.6 percent

19. Outpatients who received brain CT scans and simultaneously received a sinus CT scan: 2.7 percent

20. Outpatient CT scans of the chest that were combination or double scans: 0.044[5]

21. Outpatient CT scans of the abdomen that were combination or double scans: 0.149[6]

Hospital-acquired conditions

Figures reflect the national average rate per 1,000 discharges[7]

22. Falls and injuries: 0.527
23. Mismatched blood types: 0.001
24. Severe pressure or bed sores: 0.136
25. Air bubble in the bloodstream: 0.003
26. Infection from a urinary catheter: 0.358
27. Signs of uncontrolled blood sugar: 0.058
28. Blood infection from a catheter in a large vein: 0.372
29. Objects accidentally left in the body after surgery: 0.028

Length of stay[8]

Figures reflect national averages.

Cardiovascular and cerebrovascular conditions

Acute myocardial infarction
30. 2010: 5.3 days
31. Projected LOS in 2012: 4.8 days

Coronary artery disease and coronary atherosclerosis
32. 2010: 3.9 days
33. Projected LOS in 2012: 3.9 days

Congestive heart failure
34. 2010: 5.6 days
35. Projected LOS in 2012: 5.3 days

Stroke and acute cerebrovascular disease
36. 2010: 6.1 days
37. Projected LOS in 2012: 5.8 days

Atrial fibrillation
38. 2010: 3.7 days
39. Projected LOS in 2012: 3.5 days

Cardiovascular and cerebrovascular procedures

Coronary artery bypass graft
40. 2010: 10.1 days
41. Projected LOS in 2012: 10.1 days

Percutaneous transluminal coronary angioplasty without stents
42. 2010: 5.2 days
43. Projected LOS in 2012: 5.4 days

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Percutaneous transluminal coronary angioplasty with stents
44. 2010: 3.4 days
45. Projected LOS in 2012: 3.4 days

Aortic resection
46. 2010: 6.2 days
47. Projected LOS in 2012: 5.8 days

Carotid endarterectomy
48. 2010: 3.0 days
49. Projected LOS in 2012: 2.9 days

Patient satisfaction

The following data is based on metrics included in the Hospital Consumer Assessment of Healthcare Providers and Systems.[9]

50. Patients who gave the hospital a rating of nine or 10
Note: A rating of 10 is the highest.
Based on 3,857 hospitals.
25th percentile: 63 percent
Median: 68 percent
Average: 68.42 percent
75th percentile: 74 percent

51. Patients who gave the hospital a rating of seven or eight
Note: A rating of 10 is the highest.
Based on 3,857 hospitals.
25th percentile: 20 percent
Median: 23 percent
Average: 22.91 percent
75th percentile: 27 percent

52. Patients who gave the hospital a rating of six or lower
Note: A rating of 10 is the highest.
Based on 3,857 hospitals.
25th percentile: 6 percent
Median: 8 percent
Average: 8.67 percent
75th percentile: 11 percent

53. Patients who said, yes, they would definitely recommend the hospital to friends and family
Based on 3,858 hospitals.
25th percentile: 64 percent
Median: 70 percent
Average: 69.93 percent
75th percentile: 77 percent

54. Patients who said, yes, they would probably recommend the hospital to friends and family
Based on 3,858 hospitals.
25th percentile: 20 percent
Median: 25 percent
Average: 24.83 percent
75th percentile: 30 percent

55. Patients who said, no, they probably or definitely would not recommend the hospital to friends and family
Based on 3,858 hospitals.
25th percentile: 3 percent
Median: 5 percent
Average: 5.24 percent
75th percentile: 7 percent

56. Patients who said their room and bathroom was 'always' clean
Based on 3,858 hospitals.
25th percentile: 67 percent
Median: 71 percent
Average: 71.92 percent
75th percentile: 77 percent

57. Patients who said the area around their room was 'always' quiet at night
Based on 3,858 hospitals.
25th percentile: 52 percent
Median: 58 percent
Average: 59.02 percent
75th percentile: 66 percent

58. Patients who said their nurses 'always' communicated well
Based on 3,858 hospitals.
25th percentile: 74 percent
Median: 77 percent
Average: 76.90 percent
75th percentile: 80 percent

59. Patients who said their physicians 'always' communicated well
Based on 3,858 hospitals.
25th percentile: 77 percent
Median: 80 percent
Average: 80.61 percent
75th percentile: 84 percent

60. Patients who said they 'always' received help as soon as soon as they wanted
Based on 3,858 hospitals.
25th percentile: 59 percent
Median: 64 percent
Average: 64.93 percent
75th percentile: 70 percent

61. Patients who said their pain was 'always' well controlled
Based on 3,857 hospitals.
25th percentile: 67 percent
Median: 70 percent
Average: 69.70 percent
75th percentile: 73 percent

62. Patients who said staff 'always' explained medicines before administering
Based on 3,855 hospitals.
25th percentile: 58 percent
Median: 61 percent
Average: 61.63 percent
75th percentile: 65 percent

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63. Patients who said staff provided information about what to do during their recovery at home
Based on 3,857 hospitals.
25th percentile: 80 percent
Median: 83 percent
Average: 82.98 percent
75th percentile: 86 percent

Operational

Average full-time staff[10]
Data organized by hospital bed count
64. Bed size 6 to 24: 90
65. Bed size 25 to 49: 160
66. Bed size 50 to 99: 264
67. Bed size 100 to 199: 597
68. Bed size 200 to 299: 1,112
69. Bed size 300 to 399: 1,613
70. Bed size 400 to 499: 2,375
71. Bed size 500+: 4,405

Average part-time staff[11]
Data organized by hospital bed count
72. Bed size 6 to 24: 42
73. Bed size 25 to 49: 70
74. Bed size 50 to 99: 118
75. Bed size 100 to 199: 257
76. Bed size 200 to 299: 425
77. Bed size 300 to 399: 593
78. Bed size 400 to 499: 787
79. Bed size 500+: 1,198

Average length of stay[12]
Data organized by hospital bed count
80. Bed size 6 to 24: 4.2
81. Bed size 25 to 49: 4.8
82. Bed size 50 to 99: 5.2
83. Bed size 100 to 199: 4.6
84. Bed size 200 to 299: 4.7
85. Bed size 300 to 399: 4.8
86. Bed size 400 to 499: 5.1
87. Bed size 500+: 5.4

Full-time equivalent and facility benchmarks[13]

88. 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

89. 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

90. 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

91. Average age of plant, all hospitals
1st Quartile — 3.63 years
2nd Quartile — 7.70 years
3rd Quartile — 10.59 years
4th Quartile — 15.39 years

92. Average age of plant, investor-owned hospitals
1st Quartile — 2.12 years
2nd Quartile — 4.83 years
3rd Quartile — 8.23 years
4th Quartile — 12.96 years

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

Financial

Average costs per inpatient day

United States

Data is reflective of averages in 2010, the latest data available.[14]
94. State/local government hospitals — $1,625
95. Non-profit hospitals — $2,025
96. For-profit hospitals — $1,629

Charity care

Figures reflect average percent of total hospital expense.[15] Data based on hospitals' 2009 Schedule H forms, filed with the Internal Revenue Service .

Total charity care

Means-tested government programs and other benefits.
97. Small hospitals (less than $100 million expense): 7.3 percent
98. Medium hospitals ($100 million to $299 million expense): 8.0 percent
99. Large hospitals ($300 million or more expense): 9.8 percent
100. Systems (more than one licensed hospital): 9.3 percent

Medicare shortfall
101. Small hospitals: 2.0 percent
102. Medium hospitals: 3.6 percent
103. Large hospitals: 2.6 percent
104. Systems: 3.8 percent

Bad debt expense attributable to charity care
105. Small hospitals: 0.5 percent
106. Medium hospitals: 0.5 percent
107. Large hospitals: 0.3 percent
108. Systems: 0.5 percent

Community building activities
109. Small hospitals: 0.1 percent
110. Medium hospitals: 0.2 percent
111. Large hospitals: 0.2 percent
112. Systems: 0.1 percent

Total benefits to the community
113. Small hospitals: 9.9 percent
114. Medium hospitals: 12.3 percent
115. Large hospitals: 12.8 percent
116. Systems: 13.7 percent

Cash-to-debt ratios

Figures reflect fiscal year 2011 for non-profit hospitals.[16]

117. Overall median cash-to-debt ratio: 117.7 percent
118. Overall mean cash-to-debt ratio: 141.4 percent

119. Maximum recorded cash-to-debt ratio in Moody's sample: 936.8 percent
120. Minimum recorded cash-to-debt ratio in Moody's sample: 12 percent

121. Median cash-to-debt ratio for "Aa2"-rated hospitals: 214.5 percent
122. Median cash-to-debt ratio for "Aa3"-rated hospitals: 185.8 percent
123. Median cash-to-debt ratio for "A1"-rated hospitals: 146.9 percent
124. Median cash-to-debt ratio for "A2"-rated hospitals: 143 percent
125. Median cash-to-debt ratio for "A3"-rated hospitals: 104 percent

126. Median cash-to-debt ratio for "Baa1"-rated hospitals: 91.6 percent
127. Median cash-to-debt ratio for "Baa2"-rated hospitals: 74.6 percent
128. Median cash-to-debt ratio for "Baa3"-rated hospitals: 93 percent
129. Median cash-to-debt ratio for hospitals with ratings below "Baa": 107 percent

Median ratios

Figures reflect fiscal year 2011 for non-profit hospitals.[17]

130. Operating margin: 2.5 percent
131. Excess margin: 4.9 percent
132. Operating cash flow margin: 9.3 percent
133. Return on assets: 4.5 percent
134. Annual debt service coverage: 4.4x
135. Maximum annual debt service coverage: 4.2x
136. Current ratio: 1.9x
137. Cash on hand: 165 days
138. Cushion ratio: 14.9x
139. Cash-to-debt ratio: 117.7 percent
140. Accounts receivable: 45.1 days
141. Average payment period: 58.6 days
142. Debt-to-capitalization ratio: 40.4 percent
143. Debt-to-cash flow: 3.5x
144. Bad debt as a percent of net patient revenue: 6.1 percent
145. Capital spending ratio: 1.2x
146. Debt-to-total revenue: 36.1 percent

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147. Three-year operating revenue compounded annual growth rate: 5.4 percent
148. Cash-to-total comprehensive debt: 88 percent
149. Monthly liquidity to demand debt: 340.4 percent
150. Annual liquidity to demand debt: 373.7 percent
151. Puttable debt as a percent of total debt: 35.1 percent
152. Cash-to-demand debt: 384 percent
153. Monthly liquidity to total cash/investments: 98 percent

Investments

Figures reflect averages across 86 non-profit healthcare organizations.

154. Average investable assets in fixed income strategies: 36 percent[18]
155. Average investable assets in alternative strategies: 21 percent[19]

Average payor mix by region[20]

United States
156. Medicare: 40.9 percent
157. Medicaid: 17.2 percent
158. Worker's compensation and other government programs: 2 percent
159. HMO or PPO: 14 percent
160. Blue Cross Blue Shield, other private insurance: 16.5 percent
161. Self-pay: 4.9 percent

Northeast
162. Medicare: 42.9 percent
163. Medicaid: 15.7 percent
164. Worker's compensation and other government programs: 1.2 percent
165. HMO or PPO: 16.6 percent
166. Blue Cross Blue Shield, other private insurance: 16.6 percent
167. Self-pay: 3.2 percent

Midwest
168. Medicare: 44.5 percent
169. Medicaid: 16 percent
Worker's compensation and other government programs: n/a
HMO or PPO: n/a
170. Blue Cross Blue Shield, other private insurance: 19.2 percent
171. Self-pay: 4.5 percent

South
172. Medicare: 41.7 percent
173. Medicaid: 16 percent
174. Worker's compensation and other government programs: 3 percent
175. HMO or PPO: 11.3 percent
176. Blue Cross Blue Shield, other private insurance: 15.8 percent
177. Self-pay: 6.2 percent

West
178. Medicare: 32.9 percent
Medicaid: n/a
Worker's compensation and other government programs: n/a
179. HMO or PPO: 18.4 percent
Blue Cross Blue Shield, other private insurance: n/a
Self-pay: n/a

Public hospital finances

Figures reflect averages across members of the National Association of Public Hospitals and Health Systems from 2010.[21]

Net revenue by payor source
180. Medicaid: 35 percent
181. Commercial: 27 percent
182. Medicare: 21 percent
183. Federal/state/local payments: 11 percent
184. Other: 4 percent
185. Uninsured: 2 percent

Sources of financing for unreimbursed care
186. Federal/state/local payments: 30 percent
187. Other: 26 percent
188. Medicaid disproportionate share hospital payments: 24 percent
189. Supplemental Medicaid payments: 11 percent
190. Medicare disproportionate share hospital payments: 5 percent
191. Medicare indirect medical education: 5 percent

Hospital operating margins (national average)
192. All hospitals: 7.2 percent
193. NAPH members: 2.3 percent
194. NAPH members without Medicaid DSH: -6.1 percent
195. NAPH members without Medicaid DSH or other supplemental payments: -10.6 percent

Hospital mergers & acquisitions
Figures reflect averages from 2011.[22]
196. Average price-to-EBITDA multiple: 9.5x
197. Average price-to-revenue multiple: 0.76x
198. Average price-to-revenue multiple for critical access hospitals: 0.52x
199. Average price-to-EBITDA multiple for critical access hospitals: 8.0x
200. Average price-to-revenue multiples for distressed or bankrupt hospitals: 0.3x to 0.4x ■

References:

1. Source: iVantage Health Analytics, July 2012.

2. Source: Hospital Compare, U.S. Department of Health & Human Services. Last updated July 19, 2012.

3. Source: Hospital Compare, U.S. Department of Health & Human Services. Last updated July 19, 2012.

4. HHS maintains that a number lower than 8 percent may suggest "not enough follow-up, whereas a number higher than 14 percent may suggest "too much unnecessary follow-up."

5. The range for this measure is 0 to 1. A number close to 1 may mean that too many patients are being given a double scan when a single scan is all they need, according to HHS.

6. The range for this measure is 0 to 1. A number close to 1 may mean that too many patients are being given a double scan when a single scan is all they need, according to HHS.

7. Source: Hospital Compare, U.S. Department of Health & Human Services. Last updated July 19, 2012.

8. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project, Report 2012-02.

9. Source: iVantage Health Analytics, July 2012.

10. Source: American Hospital Association Hospital Statistics, 2012 Edition.

11. Source: American Hospital Association Hospital Statistics, 2012 Edition.

12. Source: American Hospital Association Hospital Statistics, 2012 Edition.

13. Source: 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.

14. Source: Kaiser State Health Facts, 2012.

15. Source: American Hospital Association, Schedule H Project Benchmark Report, January 2012.

16. Source: Moody's Investors Service, "U.S. Not-for-Profit Hospital Medians Show Operating Stability Despite Flat Inpatient Volumes and Shift to Government Payers," August 2012.

17. Source: Moody's Investors Service, "U.S. Not-for-Profit Hospital Medians Show Operating Stability Despite Flat Inpatient Volumes and Shift to Government Payers," August 2012.

18. Commonfund Institute, "2012 Commonfund Benchmarks Study® of Healthcare Organizations," August 2012.

19. Commonfund Institute, "2012 Commonfund Benchmarks Study® of Healthcare Organizations," August 2012.

20. Centers for Disease Control and Prevention, "National Hospital Discharge Survey." Figures reflect payor mixes from 2009, the latest year available. For categories marked "n/a," the survey had deemed those figures as not meeting a standard of reliability or precision.

21. National Association of Public Hospitals and Health Systems 2010 Characteristics Survey.

22. Irving Levin Associates, "Health Care Services Acquisition Report," 2012.

Mastering the Matrix of Healthcare: Q&A With Syd Bersante, President of St. Joseph Medical Center in Washington

By Molly Gamble

Syd Bersante, RN, has led St. Joseph Medical Center in Tacoma, Wash., as president since November 2007 after joining the hospital's parent company, Tacoma-based Franciscan Health System, in 1990. With 361 beds, St. Joseph is the flagship facility of Franciscan — a subsidiary of Englewood, Colo.-based Catholic Health Initiatives — and has undergone a flurry of development in recent years, with new telemedicine initiatives, electronic medical record implementation, a neonatal intensive care unit and other hospital-wide initiatives.

Here, Ms. Bersante discusses Franciscan's "matrix" style of management, why she believes the idea of lonely executives is old thinking and how hospitals can instill patient-centered care in their capital investments.

Question: St. Joseph opened a heart valve clinic and received approval to develop a neonatal ICU within a month of one another — that's a lot of development in a short time span. Can you tell me a bit about those developments? What other capital investments have occurred under your tenure?

Syd Bersante: We received state approval to create a Level III NICU to complement our Level II special care unit. This involves a construction project to create the unit, which will begin in February 2013. More than a capital investment, the NICU will complement the OB/Gyn services we offer. We provide the most deliveries in the area — more than 5,000 babies are born at St. Joseph and two other hospitals in the Franciscan system every year. [The NICU] piece was missing from our continuum of care for the entire Franciscan Health System. It will support our focus on patient-centered care as we won't have to transfer as many babies from St. Joseph for high-level care.

We're very proud of our new heart valve clinic. It's an additional service to our full suite of cardiac services at St. Joseph and the Franciscan organization, and reflects our desire to provide comprehensive, patient-centered care. St. Joseph is the leading provider of heart-related surgeries and other cardiac services in the region. The new clinic allows patients to come in through their primary care physician for diagnostics or surgical consultation all in one place. We all want to go to one place to be evaluated and receive a care plan through one visit. We don't want to be routed one day through diagnostics, another to a physician and so on.

We're also constructing a new medical building on the St. Joseph campus that will create destination care centers for several of our primary care and specialty care providers in the Franciscan Medical Group. Services and programs that complement the destination center practices will be in the new medical office building, so they will all be connected — physician practices, diagnostics and other specialties like neurosciences, women's care and orthopedics. The other big investment we've made is our surgical robotics program, which we started in 2008 with urology and gynecology, but have since expanded to bariatrics, general surgery and thoracic surgery.

Q: St. Joseph is also in the midst of electronic medical record implementation, correct? How has that gone so far?

SB: This is a major system-wide initiative that requires a lot of organizational attention. We're scheduled to go live in April 2013 with Epic as our clinical information technology platform. It's my responsibility to help articulate the vision for this initiative so our staff are engaged and supportive, and to ensure we have group project management and structure. It's also my role in operations to ensure there is good coordination around this initiative so we are able to maintain our high standard of patient care during the transition to an EMR.

Q: St. Joseph is expanding its telemedicine offering. How do you think hospitals can broaden telemedicine strategies while maintaining patient satisfaction and experience?

SB: I think telemedicine helps with patient satisfaction and the overall patient experience. Franciscan Anytime is the telemedicine initiative we launched in 2010 for St. Joseph employees, and we expanded it to all Franciscan Health System employees in January 2011. It's an enhancement beyond regular office hours and allows people to access medical experts via phone and webcam during the off-hours, which enables them to avoid unnecessary and costly emergency department visits.

We've prevented about 165 ED trips with an estimated cost savings of $200,000 thus far. Also, we recently expanded the telemedicine service to several of our primary care practices to give their patients an alternative for after-hours care. We are working to extend the service further so that telemedicine can be available after hours for patients of every Franciscan primary care practice.

The other thing we're doing with telemedicine is in the area of neurology and mental health. It's pretty well known that there are challenges due to a lack of physician specialists. We've found that we can connect specialists via telemedicine to provide consultative services at Franciscan's community hospitals. That's been very positive for physicians and their patients at those other sites. Physicians can access consultative services in real time and address issues quickly. This reduces the need to transfer patients from our community hospitals to St. Joseph, which creates a more positive experience for patients and their families. Additionally, we are working with psychiatrists on our medical staff so they can use telemedicine technology to serve their patients.

Q: Many leaders have brought up the topic of loneliness in the C-suite — they often feel isolated and unable to freely bounce ideas around. How do you feel about that?

SB: I think loneliness in the C-suite is kind of old thinking. Our "matrix" leadership structure promotes a team approach, in which executives can openly discuss issues and concerns. I'm president of this facility and there is a counterpart at each one of our facilities, but each one of us is also responsible for service lines that span the entire organization. [Note: Ms. Bersante oversees the cardiovascular, women's care, diagnostic imaging, wound care and pharmacy service lines for the health system.]

We interact as a team with our counterparts on a variety of issues affecting our service lines. We have twice-a-month meetings and all-day retreats once per month, where the entire team comes together to work out strategies and share ideas. We have a great culture of trust, in that we can be vulnerable at times and ask for help about things that are particularly troubling.

Another thing that helps is our succession-planning program in which we identify managers, directors and associate administrators who are up-and-comers in our organization and have the potential for larger roles. We take them through a year-long process in leadership development and use them as sounding boards for proposed changes we want to make as executives.

The other connection is with Catholic Health Initiatives. Twice a year, CHI executives gather to identify areas of concern, walk through something problematic and find new best practices. We build relationships and connections on a national level.

Q: Can you describe one of the most memorable risks you've taken and what came of it?

SB: My transition from being a clinical director to taking on a chief operating position in a facility 16 years ago was a huge transition. At the time, it seemed like a major risk because I left something in which I was very accomplished, well-thought of and successful to do something very different in terms of how I lead. I went from a role very focused in clinical care to a role with a broader reach in terms of the work you do and knowledge in how to apply different skills. There were a lot of unknowns for me. I've since learned to not be afraid of taking on, or doing, something new, because quite frankly, that's the way we grow and learn.

Q: Looking back, what advice would you offer yourself on the first day of your job?

SB: I think it's important to start making connections with key leaders in the organization: the physician leaders, staff leaders, managers and directors. Start to outline who those individuals are, because those are the people you'll start building relationships with. They also help you get a feel for the culture and how things really work. From there, connect with employees and begin to understand opportunities for improvement within the organization. ■

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In concert with key healthcare partners, Cone Health (Greensboro, NC) successfully integrated clinical and non-clinical best practices to achieve rapid improvements in the prevention of Hospital Acquired Infections (HAIs).

The Challenges

Reducing HAI-related Morbidity Rates and Costs

Deadly superbugs like MRSA, *Clostridium difficile* and *Acinetobacter* make HAIs the fourth leading cause of death in the U.S, and cost providers up to $45 billion annually. Survivors of HAIs have longer average stays (22 days). According to the Centers for Medicare and Medicaid, each case costs $23,228 in clinical care alone. With proper intervention strategies, these costs and deaths are largely preventable.

Integration of Clinical & Non-Clinical Touchpoints

Approximately 30% of HAIs originate from a contaminated clinical caregiver. The remaining 70% require strategies to address contamination in the direct "patient zone" plus common areas frequented by patients, visitors, clinicians and non-clinical staff.

The Solutions

In support of Cone Health's more comprehensive infection prevention program, Sodexo provided a combination of staffing best practices, evidence-based cleaning protocols, and new technologies.

- **Improved Employee Engagement:** Without engaged staff, investments in new technologies will underperform. A robust, behavioral-based hiring and training program was implemented with real-time behavior modification. Each Cone Health team member was CARES trained in Compassion, Accountability, Respect, Enthusiasm and Service.
- **Best-in-class processes:** As a Certified Healthcare Environmental Services Professional, the on-site leader oversees the SHINE program, which includes post-cleaning audits using Blacklight Scanners and Enzyme tests to provide instant feedback and real-time improvement of staff performance.
- **Best-in-class technology:** While several "no-touch" options exist (i.e. Hydrogen Peroxide Vapor, Mercury-based UV), Pulsed Xenon Ultraviolet has proven 99% effective for decontamination and more than 20 times as effective as traditional cleaning methods. Mobile PX-UV systems were integrated into "terminal room cleans" after patient discharge.

The Outcomes

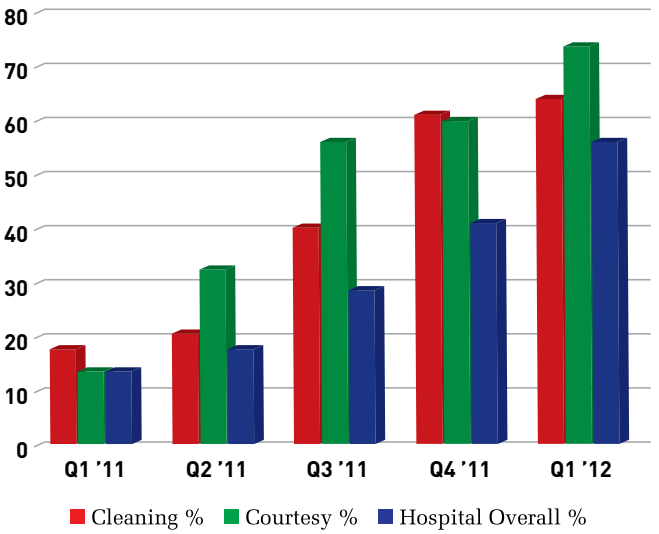
Implementing a mix of technology and behavioral, clinical and nonclinical solutions, Cone Health realized a 58% decrease in HAIs and a significant increase in its satisfaction scores.

- Total HAIs decreased from 72 in 2010 to 30 in 2011
- MRSA infections decreased from 14 to zero
- Decreased HAI-related patient days by 1,353
- Cleanliness scores for HCAHPS improved 14%, while Press Ganey gained 63 percentile points
- Employee courtesy scores soared from the 18th to the 88th percentile
- 15% gain in employee involvement, with 9% lift in overall staff satisfaction

Furthermore, Cone Health was able to substantially lower the costs associated with deadly HAI infections:

Cost of care before solutions:	$3,710,196
Cost of care after solutions:	$1,340,581
Total savings:	**$2,369,615**

The Moses H. Cone Memorial Hospital Press Ganey Patient Satisfaction



Passionate Physician Leader: Q&A with Dr. John McCabe, CEO of Upstate University Hospital

By Heather Punke

John McCabe, MD, has been a part of one facility in the Syracuse, N.Y., healthcare market for more than 25 years. As a former emergency medicine physician, he expresses concern for the patients he serves as CEO of Upstate University Hospital and what future they will face if the hospital loses funding. He cares about his employees and keeping them up-to-date in creative ways. And he is not afraid to express disappointment when a plan, that he believes will help the hospital, falls through.

Here, Dr. McCabe discusses his leadership, what changes he has overseen recently at Upstate University Hospital and how those actions will help the hospital transition into the future of healthcare.

Question: You've been with Upstate University Hospital for 26 years, and you went to medical school there as well — why did you choose to stay at one facility for so long?

Dr. John McCabe: I went to medical school here [at State University of New York Upstate Medical University] and then left for a job in Ohio. I came back to the hospital in 1987 for an emergency medicine position, where I worked to build academic and residency programs at the hospital. It was an institution I knew well and the position needed my emergency medicine training, and I haven't left since.

Q: Last year, Upstate University Hospital acquired Community General Hospital in Syracuse. What brought this deal about and why was it important for the future of the hospital?

JM: It was important for the hospital on a couple of levels. In the Syracuse market, there had been four acute-care hospitals for forever. For over 30 years, consultants would come in and say the market is too small for four hospitals, that it is better suited for three. Then last year, the hospital was full and continued to be at capacity. At the same time, Community General Hospital was the smallest hospital in the market, and it was failing. The acquisition was a smart move for both institutions — we preserved care for that hospital's traditional patient population, and it gave us the capacity we need.

Also, in today's market, academic medical centers cannot survive as high-cost tertiary care hospitals — we have to move towards becoming more of a healthcare system, and this was a step in that direction. We have to be able to offer the full range of services, from primary to specialty, from simple to complex care. The acquisition was an opportunity to add that to what we are.

Q: As the CEO of an academic medical center, what issues have you personally seen with GME funding and how do you think those problems will affect academic hospitals in the future?

JM: We have seen some decrease in GME funding in the past few years, and we are very concerned with the funding being reduced further in the future. We're also concerned about the caps put on funding. (*Editor's note:* there have been multiple proposals to cut GME funding as Congress attempts to reduce federal spending. A cap on Medicare GME funding has been in place since 1997).

What I'm seeing is more new medical schools opening up, which means that more students will be graduating from medical school, but they may not have a place to do their residency training.

My main concern is to ensure a continued source of funding for GME training. In Syracuse, 50 percent of physicians in the area trained here as residents. It is important for the community; GME funding feeds the workforce here.

Academic medical centers serve safety net functions in most communities; we take care of patients that others can't or won't. For example, things like HIV, trauma and burns, no one else does that. And when we lose GME funding on top of losing other payments from the government, we worry that we won't be able to perform those functions any more. That's the concern.

Q: Recently, Upstate University Hospital launched an electronic medical records system. Why choose to do that now, and how important do you think EMR systems are moving forward?

JM: I think electronic medical records are critical as we are moving into a new age of accountability and coordinated healthcare. We have had physician order entry and patient tracking systems in place for a long time at the hospital, so the new system is in addition to those electronic systems.

This system is designed to get our affiliated doctors offices and the hospital to share information between buildings. It was an institutional goal, and the push from the federal government helped move us in this direction.

Q: How has your background in emergency medicine helped you as a CEO?

JM: My background in emergency medicine has helped me in a few different ways as CEO.

First, emergency medicine physicians historically see anyone who comes to them, regardless of time of day or ability to pay. I take that perspective with me as CEO and I think that helps.

Second, emergency medicine physicians interact with every other specialty on a daily basis. I know how they think and what they go though.

Third, I got used to juggling 20 to 30 patients at the same time in emergency medicine. I'm a good juggler, and that has been helpful as a CEO.

Fourth, you get used to making decisions on less information than you would like to have when you practice emergency medicine. I have a comfort level of making decisions based on what little I know and my gut reaction. That helps me as a CEO.

Finally, I have been a physician, faculty member and department chair here. I understand the importance of both the medical school and the teaching hospital, so we do not have a fight between the medical school and the hospital. I understand the importance of both sides.

Q: What is the biggest challenge you've faced as a CEO?

JM: I think the hardest lesson I had to learn is that that you can't always get done what you want to get done. For example, the hospital had been looking at acquiring a nursing home in the area for a long time. My team did a great job with researching it and everything, and then we took it to the state of New York and the SUNY board and it died there. It is frustrating, and it was not the outcome I would have liked.

So I've learned that there are walls that you hit and you can't get past, even when logic would suggest that you could get past it. ■

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The Emergency Department is Overflowing With Opportunity

By Steve Whitehurst, Chief Customer and Strategy Officer, BerylHealth

In a recent study it was concluded that the U.S. healthcare system should employ simple solutions that will improve patient care and save costs due to poorly managed care transitions, which are currently contributing to high spending. As we begin to assess the past year and look forward to strategic planning for 2013, follow-up communications and more efficiently managed care coordination are areas of significance, both in the hospital and in the emergency department. With 50 percent of hospital inpatient admissions coming through the ED, and 40 percent of patients who are treated and released by ED not having a primary care physician, we look to the opportunity the ED presents for continual patient communication.

Patients don't see the emergency department as a portion of their experience separate from the total care continuum, especially if they're admitted. With a growing number of uninsured patients, the emergency department becomes the easiest access point for care, especially if patients are without a primary care physician, and the entry point for new patient populations into the system. Hospitals and health systems are beginning to panic instead of looking at the opportunity this presents for a new patient population and in revenue. Providing solutions to ensure top-scoring patient satisfaction, reducing readmissions and identifying ways to capture revenue is key in a time when reimbursement penalties seem inevitable and the main focus today.

In preparation for 2013, it's more than top-box patient satisfaction and more about addressing many issues in a more seamless fashion focused on the patient. By addressing patient satisfaction and reducing readmissions, hospitals will actualize maximum reimbursement, but that's not enough. Many systems are focused on growth and downstream revenue opportunities. One easy-to-target revenue opportunity is providing post-discharge follow-up to treated and released patients seen in emergency departments. By collectively and seamlessly addressing patient satisfaction, discharge and medication compliance, appointment follow-up and scheduling appointments, hospitals will see better patient compliance, fewer inappropriate visits to the emergency department, reduced readmissions, improved patient experiences as well as better patient retention and financial return.

Downstream revenue opportunities in the ED

While the emergency department is flooding with patients, there is significant opportunity for downstream revenue by looking at two key factors: reducing risk for readmissions/reimbursement penalties and preventing patient loss from the system after they are released from the emergency department.

Readmissions often occur because of lack of communication and clarity around discharge instructions. Of 1,159 hospitals in a *Consumer Reports* study, nearly 500 hospitals earned the lowest score for communications regarding new medications and plans following discharge, and none earned the best communication score. "That's a problem because drug errors in hospitals are common and sometimes serious, and poor discharge planning can lead to readmissions," according to the report. Readmissions can cause additional stress and suffering for the patient, and with recent changes to Medicare reimbursements, can place a heavy burden upon hospitals that are receiving significant financial penalties as a result of these readmissions. Therefore, follow-up post-discharge becomes a win-win for both the patient experience and hospital funding.

As uninsured patient numbers rise and ED volume goes up, it's a common pain point that patients use the ED as an avenue for minor episodic care, but for many of these patients, it's the first touch-point in the care continuum. It is key to look at the opportunity this presents. With more than 40 percent of patients who visit the ED not having a primary care physician, post-discharge communication to this patient population can provide the opportunity to not only check in on these patients from a health and patient satisfaction standpoint, but to also refer and schedule the patient to an in-network physician. This helps improve the patient experience, reduces the likelihood for readmission or inappropriate use of the emergency department, thus driving downstream revenue as well as patient retention and growth.

Overall, post-discharge communication works to improve population health management among high-risk patients, boosts patient compliance, improves the patient experience, provides opportunity for more efficient care coordination and prevents unnecessary readmissions — all potential drivers of hard and soft revenue leads. Specifically, by looking into strategic post-discharge planning and outbound communications, healthcare organizations can heavily impact their bottom line by shielding their reimbursement exposure and routing ED patients to the proper point of care, in-network.

When planning a strategic post-discharge and outbound communications plan, it is important to remember that not all hospitals and systems are the same. The same goes for the patient. In structuring these plans, looking at industry best practice and benchmarks as reference is always a great starting point, but be sure to consider what uniquely works for your hospital and your patients when creating your follow-up plan. In regards to the patient, targeting and understanding your patient population and the different demographic segments enables more effective communication and a better patient experience. ■

Steve Whitehurst is chief customer and strategy officer at BerylHealth, a technology based patient experience company. Mr. Whitehurst's focus at BerylHealth is to manage the overall patient experience and client facing teams, while also monitoring and aligning BerylHealth's overall business strategy with that of healthcare organizations' concerns within the market. Mr. Whitehurst welcomes your communication at steve.whitehurst@berylhealth.com , or he can be found on Twitter @Steve_Beryl.

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*Deals closed between July 2011 – July 2012, including line increases

6 Steps to Encourage Patient Safety Innovation at Hospitals

By Sabrina Rodak

Following evidence-based practices is critical for preventing harm in a healthcare setting. However, what happens when there are no evidence-based practices? Hospitals are being called upon to innovate and create patient safety protocols to fill gaps in the literature and adapt existing practices to different environments.

Detroit-based Henry Ford Health System has been recognized nationally for its commitment to patient safety and its innovative solutions to challenges. It was awarded the 2011 Malcolm Baldrige National Quality Award and the John M. Eisenberg Patient Safety and Quality Award in 2011 for reducing system-wide harm events by 34 percent and system-wide mortality by 12 percent from 2008 to 2011. William Conway, MD, senior vice president and chief quality officer of HFHS and CMO of Henry Ford Hospital in Detroit, and Sue Hawkins, senior vice president of performance excellence at HFHS, share six steps hospitals can take to drive innovation in patient safety.

1. Create a robust patient safety program. To encourage patient safety innovation, hospitals have to first create a structured program of patient safety and an infrastructure that enables people to test and share ideas. HFHS started the "No Harm Campaign" in 2008 with a goal of reducing harm events by 50 percent by 2013. The campaign has a clear structure, including committees dedicated to different kinds of harm and monthly reporting requirements.

2. Develop a culture of safety. Fostering innovation also depends on a strong culture of safety in the organization. Ms. Hawkins says HFHS develops this culture through educational offerings and training. The system also assesses leaders' and staff members' perceptions of the culture through surveys.

The employee engagement surveys also include questions related to safety assessment, from how leaders promote a culture of safety to how employees address safety concerns that arise. As part of the curriculum, each employee receives a tool kit and individual coaching on communication about safety as necessary. Leaders are expected to improve culture in their areas based on feedback from the survey. All HFHS leaders are also trained in managing a just culture when errors do occur.

3. Hold people accountable. Holding people accountable for patient safety in the organization motivates them to find ways of overcoming challenges to meet goals. In the "No Harm Campaign", HFHS' definition of harm includes all types of harm, whether preventable or not. "When you're holding the team accountable for improvement, they have to come up with innovations because if something appears to not be preventable, it's forcing you to fix it, to come up with new approaches," Dr. Conway says.

For example, following standard best practices to reduce catheter-related blood stream infections in hemodialysis patients resulted in only modest improvements at HFHS, which motivated the team to develop new best practices. HFHS established an antibiotic lock protocol, in which a solution of gentamicin and trisodium citrate is instilled into the catheter lumen after each patient's dialysis session. This practice has led to a 34 percent decrease in dialysis mortality since its implementation in 2008.

In addition, HFHS was innovative in its approach to managing anticoagulants, which is one of the highest risk medications. The team developed the Pharmacist-Directed Anticoagulation Service in 2008, a practice in which pharmacists direct the dosing of anticoagulants and follow certain protocols to manage the medications.

4. Pilot programs. Specific patient safety protocols don't have to be an all-or-nothing venture. In fact, piloting new projects provides an opportunity for leaders, physicians and staff to innovate, test new ideas and refine practices that can then be shared system-wide. Ms. Hawkins says results of pilots are shared with a steering committee all the way up to senior leadership and the board quality committee to evaluate their success.

5. Partner with researchers. Researchers can support innovation by testing new theories and providing data to support new practices. "We're a big research organization, so we have lots of physicians and scientists who love to dive into data. If we see blips we don't understand, we take a harder look at what's happening, brainstorm ideas and test them," Ms. Hawkins says.

6. Participate in outside patient safety programs. Participating in regional or national patient safety programs can spur innovation by enabling different organizations to share their successes and failures. For example, HFHS participates in the Institute of Health Improvement programs, which inspired the system to create its own method of measuring patient safety metrics, Ms. Hawkins says. ■

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5 Things No One Told Me Before I Launched an ACO

By Heather Punke

Becker's Hospital Review asked five leaders of accountable care organizations across the country to share a piece of advice that nobody told them before they launched an ACO. Respondents gave a variety of answers, including everything from the importance of one-on-one communication and claims-level data to the need of a cultural shift throughout their organization to make the ACO beneficial.

Larry B. Anderson, CEO of Tri-City Medical Center in Oceanside, Calif.: It would have been helpful in modeling our ACO to know the average Medicare spend per beneficiary, unique to our service area. This would have helped produce more accurate projections of potential savings and, therefore, allow for a more accurate presentation of the ACO concept to our participating physicians.

Work with providers you know and trust. Make sure the providers have significant experience in managing Medicare Advantage members, as the ACO concept and Medicare Advantage are very similar.

Kathryn Correia, CEO of HealthEast Care System in Minneapolis: Do not underestimate the need for communicating the changes to all of your stakeholders. I found the best way to communicate it was face-to-face — groups of medical leaders talking to small groups of physicians seemed to work well. We also used written communication and large group presentations.

Dan Doherty, Program Director of AdvocateCare, part of Advocate Health Care, in Oakbrook, Ill.: Moving from a fee-for-service to a value-based environment requires more than the development of new programs. It necessitates a significant shift in culture for leaders within the organization.

Scott Hines, Co-Chief Clinical Transformation Officer of Crystal Run Healthcare in Middletown, N.Y.: The biggest lesson that Crystal Run Healthcare ACO has learned to date is how integral claims-level data is in helping to develop strategies to reduce cost and maintain quality. As a single entity ACO comprised solely of a physician-owned, multispecialty group, we felt that we had a good sense as to what the biggest drivers of cost were based on our internal billing records. However, when we received our claims data, we were surprised to learn the degree of leakage from Crystal Run Healthcare to other facilities, particularly for tertiary care, the frequency and cost of laboratory studies ordered not just internally, but externally, and that the largest cost item to date is post-acute rehabilitation.

Now that we know the magnitude of the cost involved, we are actively pursuing relationships with tertiary care centers and post-acute rehabilitation facilities that can prove to us that they can provide the highest level of quality to our patients for the lowest cost. As for the laboratory data, we have started the process of streamlining laboratory orders and focusing our variation reduction projects on standardizing what labs are really necessary to provide quality care for our most common chronic conditions.

As we receive more and more claims-level data from CMS, we are sure that it will lead to further discoveries on novel ways to improve the quality of care that we provide while simultaneously reducing cost. This is why Crystal Run Healthcare feels very strongly that all claims-level data, from both commercial and government payers, needs to be available to providers. Only with such data on our entire patient population will we truly be able to provide "accountable care."

Simon Prince, MD, CEO of Beacon Health Partners in Manhasset, N.Y.: Look out for the vendors. Vendor interest is at a fever pitch and was underappreciated. The entrepreneurial spirit is alive and well with a seemingly endless supply of companies lined up for a piece of the ACO pie. ■


Larry B. Anderson


Kathryn Correia


Dan Doherty


Scott Hines


Simon Prince, MD

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U.S. Physician Shortage to Reach 130,000

By Heather Punke

The U.S. has 15,230 fewer primary care physicians than it currently needs, and that number could grow to 130,000 by 2025, according to data from the Association of American Medical Colleges.

The growing shortage is due to a number of factors. Healthcare reform will lead to new people gaining insurance coverage, putting additional strain on the physician population.

On top of that, 75 percent of medical school residency programs are paid for by Medicare, and the number of accepted residency students has been capped at the same number for 15 years. Also, the cost of training residents continues to grow.

"The training programs know that they are not now able to train the numbers of physicians that are going to be needed," Rep. Tom Price, MD (R-Ga.), said in a *Bloomberg* report. ■

NCQA Releases ACO Measures

By Jaimie Oh

The National Committee for Quality Assurance has published Healthcare Effectiveness Data and Information Set measures for accountable care organizations.

NCQA has specified 35 measures for ACOs. The technical specifications help ACOs define populations for ACO measurement, follow appropriate sampling and data collection methods and report ACO performance to NCQA. All ACOs are eligible to submit measure results, which will enable NCQA to create performance benchmarks and track ACO improvement over time. NCQA has also published complementary technical specifications to help ACOs collect and report their quality performance in standardized ways.

The measures will be reflected in NCQA's ACO accreditation program, which debuted in November 2011. The ACO accreditation program aligns with many aspects of the Medicare Shared Savings Program and offers three levels of accreditation to signify different levels of ACO capability, according to NCQA. ■

Providing Specialty Care Across the Country: NorthShore CEO Mark Neaman & Mayo Clinic Network Medical Director Dr. David Hayes Discuss Their Collaboration

By Kathleen Roney

In September, Evanston, Ill.-based NorthShore University HealthSystem announced it was joining the Mayo Clinic Care Network. NorthShore is the most recent health system to enter into a non-ownership relationship with Rochester, Minn.-based Mayo Clinic by joining its Mayo Clinic Care Network. Healthcare organizations in Arizona, Michigan, Minnesota, Missouri, New Hampshire and Florida are part of the network. Partner institutions include NCH Healthcare System in Naples, Fla.; Dartmouth-Hitchcock Medical Center in Lebanon, N.H.; Sparrow Health System in Lansing, Mich.; and Heartland Health in St. Joseph, Mo.

The collaboration is one of a kind in the Chicago region and will provide NorthShore patients with access to medial resources and experts from both systems working together on their behalf.

Here Mark Neaman, president and CEO of NorthShore, and David Hayes, MD, medical director of Mayo Clinic Care Network, discuss how the partnership was developed, its impact thus far and their goals for the partnership and the Mayo Clinic Care Network as a whole.

Question: Although this partnership does not deal with governance or a change of ownership, I assume it still required negotiations. How did NorthShore and Mayo Clinic begin negotiating this partnership?

Mr. Neaman: We began the discussion to join the network about two years ago when colleagues between NorthShore and Mayo Clinic were working to discover better methods to treat patients with complex medical conditions. For us, the partnership with Mayo Clinic was a way to bring additional expertise to our patients closer to home, as well as capitalize the expertise of our physicians at NorthShore by working with the expertise of physicians at Mayo Clinic. We've built a strong relationship as well as a number of tools to make quality care of these patients more accessible. What we announced was a way of formalizing what we've done over the past year.

Dr. Hayes: For the Mayo Clinic, it was coincidental that at the same time we were beginning to develop this program there was conversation from NorthShore about extending relationships. The timing was coincidental.

Q: You mentioned that you've built some tools that will aid collaboration through the Mayo Clinic Care Network. Can you elaborate on those tools?

MN: We created bi-directional tools that can assist with complex care whether a patient begins at NorthShore or Mayo Clinic. The tools enable video conferencing and electronic consultations — tools that help make sure the patient can get a second opinion without traveling across the United States. We've had over a hundred patients over the last few months that have seen benefits from the tools and the connection to Mayo physicians.

Q: Could you give an example of a patient that has benefited from the Mayo Clinic Care Network collaboration?

MN: One good example is a patient who came to NorthShore with a complex pancreatic tumor. This individual first sought care at an academic medical center and was told the condition was inoperable. He then sought a second opinion from NorthShore, and the physician he saw told him that the best course of action was to operate. The patient was then in a dilemma of what to do for a very serious disease. The physician offered the patient a consultation from the Mayo Clinic. At first the patient had the obvious questions: How will I get there? How much will it cost? The physician was able to tell the patient that NorthShore could offer an electronic consultation right away because of the partnership with the Mayo Clinic Care Network. In this instance, everyone agreed that the tumor should be operated on, and the surgery should be done at NorthShore. The patient eventually had the procedure and is now recovering.

This shows the power of teams of physicians working together on complex diseases. The patient did not need to physically travel. The patient was offered a unique comprehensive consultation that he wouldn't have had access to otherwise. That's the type of impact we see from this collaborative agreement with Mayo Clinic.

Q: Other hospitals around the country have joined the Mayo Clinic Care Network. What made NorthShore University HealthSystem want to be a part of this opportunity?


Mark Neaman


David Hayes, MD

MN: From my standpoint partnerships begin with a common organizational philosophy and an uncanny commitment to putting patients first. [NorthShore has] a large multispecialty group practice, fully integrated hospitals and long-standing commitment to an electronic medical record system, which we launched 10 years ago. We had the necessary ingredients — a similar philosophy, style, commitment to excellence and access to information technology — that made NorthShore a natural fit for the Mayo Clinic Care Network. As an innovative leader in health information technology, NorthShore

will utilize the power of our electronic medical record and advanced data collection systems to develop with Mayo Clinic best care practices, enhanced clinical decision making and improved patient outcomes.

DH: As we talk to groups about being part of our network, we are looking for organizations that are culturally aligned, patient-centric organizations, meaning the needs of the patient come first. From that standpoint, after some initial meetings it was clear that there was a good match on cultures and philosophies for NorthShore and Mayo Clinic. From there, because of the chemistry, the partnership took on the natural progression of steps.

Q: Physicians at NorthShore's Neurological Institute, Kellogg Cancer Center and Cardiovascular Center will be able to collaborate and consult with Mayo Clinic physicians through the Mayo Clinic Care Network. Is there a reason those specialty centers will be the first to use the Care Network? Do you see the Care Network service expanding to other specialties?

DH: After we go through due diligence with an organization, we launch the network for joint services in neurology, cardiology and sometimes oncology. Those are the three starting points because broad clinical areas have subspecialties that are akin to the complex care we are focusing on. We do expect the consultations to expand to other, and hopefully most, medical specialties. [For that to happen] it will be important to build relationships, keep patients in mind and look for the avenues that could be expanded.

Q: What are Mayo Clinic's goals for the Care Network? Where would you like to see these collaborative consultations lead?

DH: We hope that, down the road when it will bring value, we can bring leaders of different hospitals together to see how the network could grow or develop to do better. We envision these forums to be on the CEO, CMO or CIO level. [However], we do not know for certain if that will happen. As the network grows and we see value, it may lead to that. ■

5 Questions to Discover Cultural Compatibility in a Hospital Transaction

By Kathleen Roney

Many hospital transactions are guided by the financial fit of two hospitals. During discussions, the status and health of each hospital's finances as well as potential financial opportunities are most often discussed, and the cultural fit of the organization may be overlooked. However, it is imperative, if long-term success is a consideration, to include cultural due diligence in the overall diligence process.

"The important issue is putting culture on the table with other business performance issues. Oftentimes, it is not on anyone's radar until post-transaction, when serious performance problems arise due to poor fit between the parties. At the end of the day the transaction firms are incented by the financial opportunities and culture ends up being marginalized," says Carol Geffner, PhD, co-founder and president of Newpoint Healthcare Advisors.

"Culture is a business issue. It's not 'soft and fluffy,'" Dr. Geffner says. "Ultimately, culture determines what is and is not acceptable inside of an organization, and that directly impacts business processes and performance. At the very least, culture should be integrated into the early due diligence phases. It is not always comfortable for the investment bankers to ask the questions that will get at the issues related to cultural fit. This is one reason why some firms are using organizational psychologists as members of the diligence team."

Murray Rudin, partner at Riordan, Lewis & Haden, a private equity firm focused on investments in the healthcare, business services and government services sectors, agrees. "The objective parts of a transaction can be added up in an Excel spreadsheet very easily. The ease with which that can be accomplished has tended to give [the financial] part of the merger more attention and drawn focus away from the cultural integration. When you do not consider the influence a transaction will have on individuals, the organization suffers unanticipated operational problems," says Mr. Rudin.

In order to bring culture to the table, all hospital leaders need to do is ask a few questions. Here are five questions that should bring culture to the forefront of transaction discussions.

1. What is the culture at both hospitals? Hospital executives need to ask about a potential partner's values in order to understand its culture. According to Dr. Geffner, the aim is to discover the gap between what is stated and what actually happens. One way to get at this is to ask questions about key decisions and how they were made and then executed. Another more objective approach is to review data within both companies on employee satisfaction, organizational effectiveness and SWOT information, which highlights strengths, weaknesses, opportunities and risks. According to Dr. Geffner, these can also lead to more thorough discussion on what is at the heart of the organization's "DNA."

"Values can be very important. That is a key element. But, you don't know whether people 'walk the talk' every day or if they are just values on a wall. The questions about culture should be about the origin of values, how they are reinforced and how they are reflected. This could yield rich conversation," says Dr. Geffner. The following questions are a great way to start the conversation and to dig deeper for a better picture of how the organization's culture functions.

- Can you tell me about the hospital's values?
- Can you tell me how the hospital's values are perceived within the organization?
- Can you speak to how the hospital's values originated?
- How long has the hospital followed these values?
- How are the values reinforced internally?

2. How does the leadership team reflect the hospital's culture values? Dr. Geffner recommends asking about the potential partner's leadership team, given their importance in shaping what actually transpires inside the organization. "Many times a hospital's leadership team will reflect an organization's culture and values — what is actually rewarded and tolerated — so asking how the leadership team reflects the values and strategic priorities of the hospital can lead to a revealing discussion," says Dr. Geffner. "If there is interest in retaining some of the leaders of the acquired company, it is critical to dig into their reputation within the organization, not just their performance. It's prudent to surface information about leadership style early on, rather than leaving that to a post-transaction inquiry when damage may have been done," she says.

According to Nitsa Lallas, partner and healthcare practice leader for Senn Delaney, a culture shaping firm, spending time with the leadership team can tell you a lot about the culture of an organization. "How hospital leaders behave is more important than what they say. We call this Shadow of the Leader. Is how they behave matching what they say? What example are they setting? Are they walking the talk?" says Ms. Lallas. The leadership shadow cast by members of this team and the overall team can be telling of a hospital's true culture.

The following questions about the leadership team are effective for revealing a leader or leadership team's shadow in order to discover a hospital's cultural priorities.

- Are the values used as criteria for hiring new executive leadership?
- How are new team members oriented to the hospital's values?
- Does the leadership team use the values to align on making decisions for the organization?
- Is the team's similar background on purpose or coincidental?
- How do the leaders engage and inspire employees to live the hospital's values?

3. What are the specific business achievements? Are there examples of the culture through action? According to Dr. Geffner, hospital executives should never be satisfied with high-level descriptions of how critical decisions were made. Details are important. There are many questions that can yield insight into how the company functions.

- Who led a particular initiative?
- Who was involved all the way through the process? How?
- How long did the team take to reach a solution?
- Who was impacted by the decision? How were they actively involved in the decision making?
- Do you have examples of the communications that were sent about this initiative and the solutions?

"Let the other organization talk about specifics and then use that as a platform for more detailed questions," says Dr. Geffner.

4. What are the strengths and weaknesses of your culture? According to Ms. Lallas, another way to determine a hospital's culture is to ask the executives to discuss their organization's strengths and where they need improvement. "Executives should have a good sense of their culture, including how it helps and hinders the organization's operations. Questions to ask include: What are the cultural behaviors that lead to success? What behaviors are getting in the way? How do you address behaviors that are not aligned with the hospital's values?" says Ms. Lallas. She also adds that it is very important to understand the cultural similarities and differences between the merging hospitals. Executives that have a clear vision of their hospital's vision, values and guiding behaviors understand how they impact the quality and efficiency of their healthcare services. This understanding also better prepares them to be successful in culturally integrating with another hospital.

5. Can you discuss why your hospital's culture was perceived this way? According to Dr. Geffner, the due diligence of a transaction will reveal external perceptions of the hospital, which may offer insight into their level of insularity or customer-centricity. "The perceptions of the community, former employees and former leaders surface during due diligence. This information will provide clues not only about perceptions but the extent to which the business has involved external entities such as customers, vendors and the community in overall decision making. The external perceptions — right or wrong — can be a platform for an effective discussion on the real vs. described culture," says Dr. Geffner.

However, perceptions are not always accurate, so while asking about them can garner rich conversation, hospital executives should do their own research. "One of the diligence points about organizational culture is not only what the business says about itself but what others say — the former employees, executives and patients. It may also be a good idea to ask to see employee satisfaction surveys — not to be judgmental, but to get a sense of what the employees like and do not like," says Mr. Rudin.

There is no right or wrong in a cultural discussion

Before beginning a cultural discussion it is important for hospital executives to remember to leave judgment out of the assessment. Many hospitals and organizations have succeeded in a variety of cities with a range of cultures. "There is no right or wrong or better or worse in a cultural discussion," says Mr. Rudin. "It is not that black and white. I think it would be fair to say that a cultural assessment should be non-judgmental. [Executives] should only be looking at whether there is a compatible way to combine the two organizations," he says.

Cultural issues are gaining visibility for mergers and acquisitions in the healthcare industry because they are a key factor in how a hospital operates. Although every hospital is different, addressing the cultural compatibility and integration between two healthcare organizations in transaction discussions is a key best practice. Delaying the cultural discussion only hurts the transaction. "The financial integration [in a transaction] is the easiest. The system integration is more difficult, [but] the cultural integration is by far the hardest," says Mr. Rudin. For this reason, hospital executives need to be prioritizing culture. ■

HHS Finalizes One-Year Delay of ICD-10 to 2014

By Bob Herman

HHS issued a final rule this August that officially changes the compliance date of ICD-10 from Oct. 1, 2013, to Oct. 1, 2014.

In April, HHS proposed to delay the ICD-10 compliance date to Oct. 1, 2014, and it stayed with that option because it "is most likely to minimize the costs of delay and to maximize the benefits to providers who need more time to implement," according to the final rule.

HHS estimated that the one-year delay of ICD-10 could cost a hospital with 400 or more beds up to $6.16 million. Hospitals with 100 to 400 beds could lose up to $1.85 million, and hospitals with fewer than 100 beds could be affected by $310,000.

"Weighing the risks and consequences of a disruption to healthcare claim payments…we believe that a one-year delay in the implementation date strikes the best regulatory balance," HHS officials wrote. "It is our best judgment that, to go forward with the original compliance date would risk disruptions on many levels, while a delay of any more than a year would incur costs that could not be justified in the name of avoiding risk."

Also in the final rule, HHS finalized the establishment of a unique health plan identifier. Currently, when a hospital bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. Consequently, hospitals and other providers could run into time-consuming problems, such as misrouting of transactions and difficulty determining patient eligibility. HHS expects HPIDs to save up to $6 billion over the next 10 years.

"These new standards are a part of our efforts to help providers and health plans spend less time filling out paperwork and more time seeing their patients," HHS Secretary Kathleen Sebelius said in a news release. ■

Hospitals, Providers to Lose $11.1B From Medicare Sequestration Cuts

By Bob Herman

Hospitals and other providers will see Medicare payment reductions totaling $11.1 billion this upcoming year due to the Budget Control Act of 2011, unless Congress passes new measures to prevent the cuts, according to a report from the White House's Office of Management and Budget.

Last summer, the bipartisan Joint Select Committee on Deficit Reduction, more commonly known as the "supercommittee," was unable to reach an agreement on ways to reduce the national deficit. As such, the Budget Control Act of 2011's sequestration process became the default plan to reduce the deficit by $1.2 trillion over the next 10 years via across-the-board budget cuts to all government agencies.

In the sequestration plan, roughly $109 billion of cuts would be implemented every year from fiscal year 2013 to FY 2021. Defense spending would take the biggest hits with cuts of 9.4 percent. Nondefense spending would be reduced by 8.2 percent, most entitlement programs by 7.6 percent and Medicare by 2 percent.

Two percent of Medicare's budget ($554.3 billion) is roughly $11.08 billion. Medicare providers — ranging from hospitals and physician practices to home health agencies and hospices — would see reductions in their payments, but Medicare beneficiaries would not lose any of their benefits. Over the next 10 years, Medicare providers stand to lose upwards of $120 billion.

In addition to the Medicare cuts, the National Institutes of Health would also have to "halt or curtail scientific research, including needed research into cancer and childhood diseases," according to the OMB's report.

President Barack Obama and the OMB said the sequestration process is a "blunt and indiscriminate instrument," and the reductions could be "destructive" to the country's social programs, national security and other governmental functions. President Obama has called on Congress to "act responsibly" and put forward a new proposal.

"[Sequestration] is not the responsible way for our nation to achieve deficit reduction," according to the OMB's report. "The President has already presented two proposals for balanced and comprehensive deficit reduction. It is time for Congress to act. Members of Congress should work together to produce a balanced plan that achieves at least the level of deficit reduction agreed to in the BCA that the President can sign to avoid sequestration. The administration stands ready to work with Congress to get the job done." ■

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Cardiology & Medical Necessity: How Your Hospital Can Avoid Heart-Related Investigations

By Bob Herman

This past August, the U.S. Department of Justice sent guidelines to hospitals that dealt with the medical necessity of implantable cardioverter defibrillators, or ICDs.

The guidelines were released to help with the settlement of claims stemming out of the DOJ's investigation on ICDs that were placed in Medicare beneficiaries between 2003 and 2010 at hospitals. Hundreds of hospitals stand to face False Claims Act penalties for improper use of ICDs as a result of the investigations, which as most hospitals going through fraud and abuse measures right now know can be a very costly process.

ICDs have been heavily scrutinized by governmental agencies for roughly the past five years, especially considering the cost of implanting ICDs can range between $30,000 and $40,000. Beyond ICDs, cardiac care in general has been a lightning rod of scrutiny due to the high costs and high amounts of fraud associated with it. This past August, a *New York Times* investigation alleged that Nashville, Tenn.-based Hospital Corporation of America performed medically unnecessary cardiac catheterization procedures from 2002 through 2010.

Here are some quick steps hospitals can take to make sure their physicians are being prudent in their discretion of cardiac-related procedures and devices.

1. Document everything. Lee Lasris, JD, a founding partner of the Florida Health Law Center in Davie, Fla., has represented numerous hospitals and health systems over the past 30 years. When it comes to cardiac care, like most other Medicare covered items and services, he says it is essentially a medical necessity determination. Medicare wants to be sure that high-dollar procedures and implants, like ICDs and stents, are being utilized only when medically necessary and not for the convenience of the physician.

CMS defines medical necessity in its national coverage determinations, which are the definitive guidelines of whether Medicare will pay for an item or service. When it comes to ICDs, NCD 20.4 governs Medicare's payment of ICDs and can be found on CMS' website. Some stipulations include the timing of when ICDs are implanted: heart attacks must occur more than 40 days prior to ICD insertion; the diagnosis of heart failure must occur more than three months prior to ICD insertion; angioplasties or bypass surgeries must occur more than 90 days prior to ICD insertion; etc.

Mr. Lasris says while there are well-meaning physicians who want to insert ICDs sooner rather than later — for example, when the patient is already on the operating table for a different procedure — the NCD must be kept in mind, and legitimate medical reasons for doing so must be well-documented if the physician wants to avoid the claim being denied for failure to follow the guidelines.

With that in mind, the greatest defense a hospital can have to justify its use of ICDs and other cardiology-related procedures and devices is clear, coherent, reasonable and legitimate documentation. Educating physicians on the specific documentation requirements is one of the most important things a hospital can do to ensure its rationales are solid and able to be traced. The DOJ's resolution and guidelines highlight specific documentation requirements, and hospitals and their physicians must sit down and have a plan of action for their future ICD documentation.

"You need to be able to document why you did something," Mr. Lasris says. "If there's a good reason, Medicare will eventually pay it. Medicare is a reasonable payor."

Tony Brett, JD, a partner with Womble Carlyle Sandridge & Rice in Winston-Salem, N.C., who also works with hospitals, agrees that physician documentation, in accordance with Medicare guidelines, will keep hospitals and physicians in the clear. "If your physicians can justify what you're doing, OK. You can sleep better at night," Mr. Brett says. "But you have to know if the problem is the implantations themselves or the documentation. Physicians are busy and would rather treat patients than treat paper. They may not realize all the things they need to document."

2. Self-audit. Instead of awaiting notices from the DOJ or Office of Inspector General, hospitals should remain proactive and ensure that their cardiology processes are legitimate through self-audits. Hospitals may already be self-auditing themselves for other fraud and abuse measures — such as those instigated by Medicare Recovery Auditors, or RACs — and Mr. Brett says hospitals and physicians should take the time to self-audit on cardiology procedures, especially if they believe there may have been inappropriate ICD or stent insertions in the past.

"If you think you have might have an issue, you ought to look at the implantations that have occurred," Mr. Brett says. "Do they match up with the criteria? If not, is there documented rationale that would be recognized by physicians in the area that would be used as justification?"

Monthly self-audits may seem like another administrative burden, but they very well could be cheaper in the long run as hospitals could avoid unintentional federal violations. "It's always cheaper to self-report and stay under the False Claims Act," Mr. Lasris says.

3. Talk with peers. Hospitals and physicians need to collaborate not only amongst each other, but also with peers, to see if their rate of ICD implantation is comparable with state and regional averages. Simply talking with peer institutions can give hospitals a clearer idea of whether they may flag interest from government regulators.

"Consult with a peer," Mr. Brett says. "It's not to say two people can't be wrong, but it's less likely."

4. Don't be afraid to ask the government questions. Alberto Gonzales, JD, former U.S. Attorney General under President George W. Bush and now an attorney at Waller Lansden Dortch & Davis, says the DOJ will review the ICD implantations at hospitals on a case-by-case basis. The guidelines and resolution model will help with settlements regarding the DOJ's investigation. Overall, Mr. Gonzales believes most hospitals will settle, depending on their individual cases.

However, hospitals in dialogue with the DOJ should use the opportunity to make sure every party is on the same page. No one likes to be investigated by the DOJ, or any other prosecutor, so hospitals should ask the important questions to ensure there is no confusion in the future, he says.

"When I worked with the DOJ, I always found things were better when there was ongoing communication with the prosecutor," Mr. Gonzales says. "If there are questions, ask. Sometimes, it's a good idea to consult with the DOJ if you want to do something, or take certain action. Run your concerns by the investigator or prosecutor to make sure they are OK with it." ■

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Providers Can't Challenge Year-Old RAC Audits, Court Rules

By Molly Gamble

The Ninth U.S. Circuit Court of Appeals has ruled that healthcare providers cannot challenge Medicare Recovery Auditors' review of claims that are more than a year old.

Palomar Medical Center in Escondido, Calif., filed suit in 2009 against HHS, challenging a 2007 RAC audit that reopened a claim 20 months after the claim's initial payment. The audit found the hospital was overpaid for the claim, as medical services were deemed "not reasonable and necessary," according to an *American Medical News* report.

Under Medicare regulations, RACs can review claims less than a year old for any reason. If the claim is between one to four years old, RACs must have a good cause to reopen the claim. If older than four years, auditors must have clear evidence to review the claim.

Palomar fought the RAC finding, arguing that the RACs did not have the right to reopen the claim under the regulated time frame.

An administrative law judge ruled that the auditors had not demonstrated good cause to examine the claim, but the Medicare Appeals Counsel reversed that decision, claiming the ALJ lacked jurisdiction to determine whether the RAC had lawfully opened the claim.

Palomar appealed the counsel's decision, but a district court ruled in favor of HHS in 2010. In its August decision, the Ninth Court of Appeals ruled that "in view of the goals of the RAC program, and the secretary's regulations stating that decisions to reopen are 'final' and 'not appealable,' we hold that the issue of good cause for reopening cannot be raised after an audit's conclusion and the revision of a paid claim for medical services," according to the report.

The ruling holds many implications for physicians and hospitals, which must accept audits without challenge, according to the report. Generally, the further back an audit goes, the more disruptive it is for providers, as it can create a larger administrative burden. ■

California AG Investigates Hospital-Physician Deals for Antitrust Violations

By Molly Gamble

California Attorney General Kamala D. Harris is investigating whether affiliation agreements between physicians and several large hospital operators are in violation of antitrust law.

The investigation has been underway for several months. The AG is examining how hospitals are being reimbursed by insurers and if hospital-physician deals are giving hospitals more market power to raise their prices.

The AG sent subpoenas to San Francisco-based Dignity Health, San Diego-based Scripps Health and Sharp HealthCare and Sacramento-based Sutter Health, among others, according to the report. Major California health insurers have also received subpoenas.

Scripps said it is cooperating with the AG's subpoena, which "appears to be related to antitrust issues" but said it did not know specifics of the inquiry. Other systems confirmed their receipt of the subpoena but did not disclose further information about the investigation. ■

3 Major Trends for Call Coverage, Medical Direction

By Bob Herman

Payments for physician call coverage and medical direction from hospitals have increased over the past few years, as hospitals are facing mounting pressures to enhance their physician base.

Call coverage, leadership services and other physician services contracted by hospitals all require different compensation structures, and they have been growing and changing as the industry struggles to address the challenges of healthcare reform.

Penny Stroud, CEO of MD Ranger, discusses the trends in these three major categories from the firm's third annual physician contract benchmark report, which used unique data from more than 5,000 physician contracts from more than 220 hospitals.

1. Call coverage. Most call coverage and medical direction payments to physicians did not change much between 2010 and 2011, but those that did change rose dramatically. For emergency call coverage, Ms. Stroud says new contracts spiked by an average of 8.8 percent — more than double the prior year's increase.

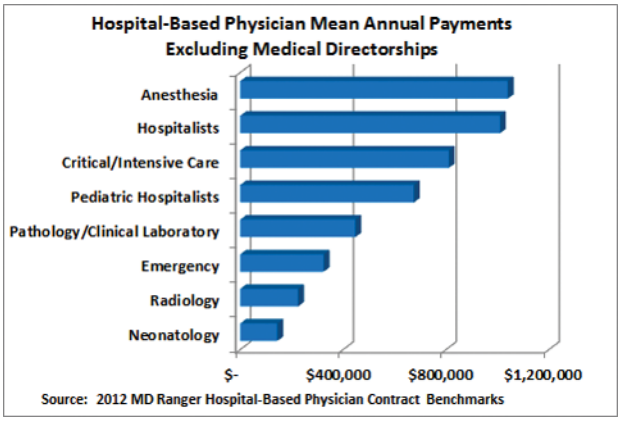
The biggest factor impacting payments rates is the trauma status of a hospital, which Ms. Stroud says is not surprising. Trauma hospitals have more stringent coverage requirements and typically have higher volume and a poorer payor mix. In addition, many specialties require onsite coverage, which is also associated with higher rates. Trauma hospitals usually pay a 22 percent premium for coverage, and restricted call garners an even higher premium at 40 percent.

"Trauma continues to outpace every other factor as a driver of costs," Ms. Stroud says. "And that relates both to the number of contracts from hospitals as well as the cost of those contracts. However, non-trauma hospitals are also facing heavy pressure to pay for call."

2. Medical directorships and administrative/leadership services. Physicians have increasingly taken on new roles within the hospital, and both medical directorships and other initiatives such as quality, electronic health records and readmission reduction programs have been at the forefront.

Last year, Ms. Stroud says MD Ranger benchmarks increased modestly for medical directorship contracts. Roughly 13 percent of medical director contracts had rate increases, while 10 percent had rate decreases. "We've seen medical director contract rates, on an annual basis, trend up, but at a lower pace than last year," Ms. Stroud says. "In 2010, contracts with a change increased 4 percent, while in 2011 the average increase for contracts with a rate changes was only 1.6 percent."

Ms. Stroud says there were some other, more specific findings on medical directorship and administrative contracts. For example, hospital heart center directorships are the highest-paid, non-hospital-based specialty. Administrative contracts in surgical specialties have the highest hourly rates at a median of $200 per hour compared with $150 an hour for other specialties.



3. Hospital-based physician contracts. One of the more unique aspects of MD Ranger's physician compensation contract report is the comprehensive report on nine hospital-based services. These specialties are often paid comprehensive stipends that include coverage, medical direction, administrative services and payment for uncompensated care. They represent some of the highest physician expenses for hospitals, and they are generally paid to a single specialty medical group with exclusive privileges for the service.

For example, the mean annual payment for hospital-based physician contracts in anesthesia, excluding medical directorships, was around $953,000 last year, Ms. Stroud says. There is a very broad range of payments for these hospital-based services — neonatology has a low mean of $144,000, and pathology is around $298,000 per year. "Anesthesia, hospitalist and intensivist services typically command the highest stipends," Ms. Stroud says. "For many hospitals, these contracts are a very heavy burden. Anesthesia and hospitalists are the most expensive services; however, payment rates vary dramatically and often depend on hospital size, location and payor mix."

The 2012 MD Ranger report also includes benchmarks for administrative and other services, such as chief of staff, electrocardiography reads and uncompensated care. ■

13 Statistics on Daily Stipends and On-Call Physician Compensation

By Bob Herman

The most common form of on-call compensation for physicians is a daily stipend, according to the Medical Group Management Association's *Medical Directorship and On-Call Compensation Survey: 2012 Report Based on 2011 Data.*

Roughly 30 percent of physicians included in MGMA's survey said they receive daily stipends for days on-call. Here are 13 statistics on how daily stipends differed among different physician specialties. (Note: All statistics are median stipend figures per day of on-call coverage.)

Specialties

- Anesthesiologists: $1,500
- Internal medicine physicians: $1,000
- Noninvasive cardiologists: $650
- Family medicine physicians (without obstetrics): $100

Medical group type

- Anesthesiologists in multispecialty practices received $760 more per day in median on-call compensation than anesthesiologists in single-specialty practices.
- Neurosurgeons in single-specialty practices received $800 more per day in median on-call compensation than neurosurgeons in multispecialty practices.
- Invasive-interventional cardiologists earned 30 percent more in single-specialty practices than those in multispecialty practices.

Demographics

- General surgeons in the East: $920
- General surgeons in the Midwest: $500
- General surgeons in the South: $854
- General surgeons in the West: $1,000
- Neurosurgeon range across all regions: $1,600 to $1,830 ■

104 Statistics on Hospital Executive Salary Growth

By Bob Herman

Hospital executive salaries have endured many ups and downs before, during and since the economic collapse of 2008. A recent survey from Yaffe & Company, a healthcare compensation consulting firm, pulled data from 267 hospitals and health systems. Sixty-five percent of respondents were single-hospital systems, and 51 percent had net patient revenue between $35 million and $199 million.

Here's what they found regarding salary adjustments for four primary hospital executive titles.

Hospital CEOs

Hospital CEOs have seen steady salary increases over the past eight years, perhaps most steady of all hospital executives. Most CEOs receive raises of at least 4 percent, and before the economic collapse of 2008, salary raises went as high as 7.36 percent.

Average hospital CEO salary adjustments by year

2004-2005: 6.57 percent
2005-2006: 6.47 percent
2006-2007: 7.36 percent
2007-2008: 5.61 percent
2008-2009: 6.70 percent
2009-2010: 4.10 percent
2010-2011: 3.90 percent
2011-2012: 4.09 percent

Average hospital CEO salary adjustments by net patient revenue and percentiles

Hospitals with net patient revenue less than $35 million
25th percentile: 0 percent
50th percentile: 2.2 percent
75th percentile: 6.4 percent

Hospitals with net patient revenue between $35 million and $99 million
25th percentile: 0 percent
50th percentile: 3.1 percent
75th percentile: 6.8 percent

Hospitals with net patient revenue between $100 million and $199 million
25th percentile: 0 percent
50th percentile: 2.2 percent
75th percentile: 3.6 percent

Hospitals with net patient revenue between $200 million and $500 million
25th percentile: 0 percent
50th percentile: 3.4 percent
75th percentile: 7.2 percent

Hospitals with net patient revenue greater than $500 million
25th percentile: 1.6 percent
50th percentile: 2.5 percent
75th percentile: 4.6 percent

Total
25th percentile: 0 percent
50th percentile: 2.7 percent
75th percentile: 5.8 percent

Hospital CFOs

Similar to hospital CEOs, hospital CFOs have received higher-than-average base salary raises, but they are lower than the raises issued before the 2008 economic collapse. Hospital CFOs can usually expect a raise between 3 and 5 percent on a year-to-year basis, and before 2008, raises topped 6 and 7 percent.

Average hospital CFO salary adjustments by year

2004-2005: 5.67 percent
2005-2006: 5.96 percent
2006-2007: 5.25 percent
2007-2008: 6.25 percent
2008-2009: 7.31 percent
2009-2010: 3.00 percent
2010-2011: 4.27 percent
2011-2012: 5.92 percent

Average hospital CFO salary adjustments by net patient revenue and percentiles

Hospitals with net patient revenue less than $35 million
25th percentile: 0 percent
50th percentile: 1.9 percent
75th percentile: 7.3 percent

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Hospitals with net patient revenue between $35 million and $99 million
25th percentile: 0 percent
50th percentile: 2.1 percent
75th percentile: 5 percent

Hospitals with net patient revenue between $100 million and $199 million
25th percentile: 2 percent
50th percentile: 3.7 percent
75th percentile: 5.6 percent

Hospitals with net patient revenue between $200 million and $500 million
25th percentile: 1.3 percent
50th percentile: 5 percent
75th percentile: 11.7 percent

Hospitals with net patient revenue greater than $500 million
25th percentile: 2.6 percent
50th percentile: 3.3 percent
75th percentile: 3.9 percent

Total
25th percentile: 0 percent
50th percentile: 3.5 percent
75th percentile: 7.1 percent

Hospital CMOs

Hospital CMOs received base salary raises as high as 10.17 percent in 2006, but their salary adjustments have been cut by more than two-third since then. However, the 10 percent salary hikes are the single largest adjustments of any hospital executive in the past eight years.

Average hospital CMO salary adjustments by year

2004-2005: 6.88 percent
2005-2006: 10.12 percent
2006-2007: 10.17 percent
2007-2008: 5.21 percent
2008-2009: 5.68 percent
2009-2010: 3.08 percent
2010-2011: 4.47 percent
2011-2012: 3.10 percent

Average hospital CMO salary adjustments by net patient revenue and percentiles

Hospitals with net patient revenue less than $35 million
25th percentile: 0.5 percent
50th percentile: 1 percent
75th percentile: 1.5 percent

Hospitals with net patient revenue between $35 million and $99 million
25th percentile: 0 percent
50th percentile: 1 percent
75th percentile: 3 percent

Hospitals with net patient revenue between $100 million and $199 million
25th percentile: 0.4 percent
50th percentile: 2 percent
75th percentile: 3 percent

Hospitals with net patient revenue between $200 million and $500 million
25th percentile: 0 percent
50th percentile: 3 percent
75th percentile: 9 percent

Hospitals with net patient revenue greater than $500 million
25th percentile: 0 percent
50th percentile: 2.5 percent
75th percentile: 3 percent

Total
25th percentile: 0 percent
50th percentile: 2 percent
75th percentile: 4 percent

Hospital CNOs

Over the past three years, hospital CNOs have had the lowest rates of salary growth compared with CEOs, CFOs and CMOs. CNOs, on average, have not seen salary raises above 4 percent since 2008, and CNO salary adjustments have not topped 7 percent in the past eight years.

Average hospital CNO salary adjustments by year

2004-2005: 5.42 percent
2005-2006: 6.94 percent
2006-2007: 6.11 percent
2007-2008: 6.27 percent
2008-2009: 6.69 percent
2009-2010: 2.75 percent
2010-2011: 2.81 percent
2011-2012: 3.94 percent

Average hospital CNO salary adjustments by net patient revenue and percentiles

Hospitals with net patient revenue less than $35 million
25th percentile: 0 percent
50th percentile: 0.1 percent
75th percentile: 3.6 percent

Hospitals with net patient revenue between $35 million and $99 million
25th percentile: 0 percent
50th percentile: 3 percent
75th percentile: 4 percent

Hospitals with net patient revenue between $100 million and $199 million
25th percentile: 1 percent
50th percentile: 2.8 percent
75th percentile: 4.5 percent

Hospitals with net patient revenue between $200 million and $500 million
25th percentile: 0.3 percent
50th percentile: 3 percent
75th percentile: 6.6 percent

Hospitals with net patient revenue greater than $500 million
25th percentile: 2.5 percent
50th percentile: 3.5 percent
75th percentile: 5 percent

Total
25th percentile: 0 percent
50th percentile: 3 percent
75th percentile: 5 percent ■

An IT Boondoggle?

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

A recent *Wall Street Journal* article left me speechless. Like a lot of other people in healthcare I have been indoctrinated with the belief that unless the industry fully and enthusiastically adopts information technology, hospital and health systems will never run efficiently and be able to deliver quality healthcare to patients. I have attended HIMSS conferences, read articles, and been told by countless IT vendors and consultants and the United States government that every healthcare entity must be totally "wired" to be efficient and effective.

Reading the article Stephen Soumerai, a professor of population medicine at Harvard Medical School and Harvard Pilgrim Health Care Institute, and Ross Koppel, a professor of sociology and medicine at the University of Pennsylvania, has shaken my belief.

In two years, thousands of hospitals and physicians that fail to buy and install costly healthcare information technologies, such as digital records for patient histories and prescriptions, will face penalties through reduced Medicare and Medicaid payments. By that time, the government will have paid out tens of billions of dollars in subsidies and incentives to providers who install these technology programs — the carrot before the stick.

The mandate, part of the 2009 stimulus legislation, was the goal of healthcare information lobbyists and their friends in Congress and the White House. This is no small thing, since the lobbyists claimed and promised that these technologies would make medical administration more efficient and lower medical costs by up to $100 billion annually. However, from the very beginning many physicians and hospital administrators have been skeptical of these claims because of their own first-hand experiences.

Professors Soumerai and Koppel say that the software sold by hundreds of health IT firms is "generally clunky, frustrating, user-unfriendly and inefficient." A good example of this could be a doctor looking for a patient's current medications having to click and scroll through many different screens to find essential information. It is time-consuming and cumbersome.

Despite this, since 2009 almost a third of health providers have installed at least some healthcare IT technology. "It wasn't cheap," Mr. Soumerai and Mr. Koppel note. "For a major hospital, a full suite of technology products can cost $150 million to $200 million. Implementation — linking and integrating systems, training, data entry and the like — can raise the total bill to $1 billion."

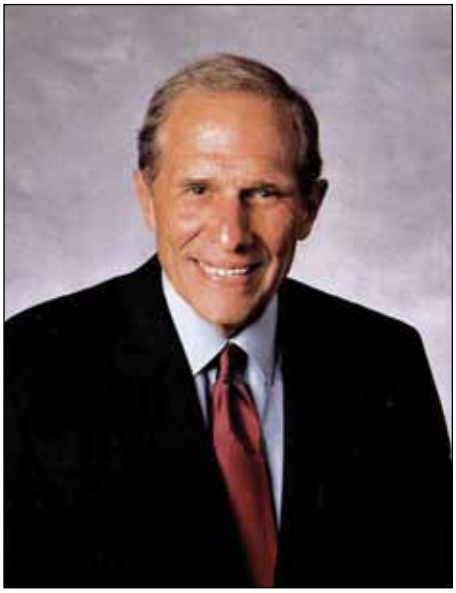
The authors claim that a new evaluation of the scientific literature has confirmed what many researchers suspected: The cost savings claimed by government agencies and vendors of health IT are little more than hype. Mr. Soumerai and Mr. Koppel cite research done by the faculty of McMaster University in Hamilton, Ontario, and its programs for assessment of technology in health, along with other research centers, including in the U.S. Researchers sifted through almost 36,000 studies of health IT. "The studies included information about highly valued computerized alerts — when drugs are prescribed, for instance — to prevent drug interactions and dosage errors. From among those studies researchers identified 31 that specifically examined the outcomes in light of the technology's cost-savings claims," they write. The findings showed that with a few isolated exceptions the systems had not improved health or saved money.

Another study by Regenstrief, a leading health IT research center associated with the Indiana University School of Medicine, also found that there were no savings from IT. A second Regenstrief study found a significant increase in costs of $2,200 per physician per year from electronic records.

"In short, the most rigorous studies to date contradict the widely broadcast claims that the national investment in health IT — some $1 trillion will be spent, by our estimate — will pay off in reducing medical costs," Mr. Soumerai and Mr. Koppel conclude. "Those studies that do claim savings rarely include the full cost of installation, training and maintenance — a large chunk of that trillion dollars — for the nation's nearly 6,000 hospitals and more than 600,000 physicians."

According to the authors, the sad thing about all of these studies and their findings is the fact that by the time healthcare providers find out that the promised cost savings are an illusion, it will be too late. In other words, after having spent millions upon millions of dollars on the technology they will not be able to throw it out like you would any defective piece of machinery.

Furthermore, according to the authors, it is "common knowledge in the healthcare industry that a central component of the proposed health IT system — the ability to share patients' health records among doctors, hospitals and labs — has largely failed. The industry could not agree on data standards — for instance on how to record blood pressure or list patients' problems. Instead of demanding unified standards, the government has largely left it to the vendors, who declined to cooperate, thereby ensuring years of noncommunication and noncoordination. This likely means billions for unnecessary repeated tests and procedures, double-dosing patients and avoidable suffering."



The authors also state that so strong is the belief in health IT that skeptics and their science are not always welcome. They note that articles that were published years ago in the *Journal of the American Medical Association* and the *Annals of Internal Medicine* reported that health IT systems evaluated by their own developers were far more likely to be judged "successful" than those assessed by independent evaluators.

The authors end their article with a cautionary note. "We fully share the hope that health IT will achieve the promised cost and quality benefits. As applied researchers and evaluators, we actively work to realize both goals. But this requires an accurate appraisal of the technology's successes and failures, not a mixture of cheerleading and financial pressure by government agencies based on unsubstantiated promises."

If people in this industry don't wake up and wake up soon we are destined to see an untold amount of money needlessly wasted on technology. Importantly, the federal government needs to take a long, hard look at requiring something that may harm, not help. Remember, this is an industry already awash in wasteful spending on care, at least a third of it with absolutely no benefits to patients. This is why mature leadership is critically necessary to bring reason to an industry already facing incredible financial constraints. We can only hope. ■

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.*

4 Strategies to Boost Hospitals' HCAHPS Scores

By Sabrina Rodak

Hospitals' scores on the Hospital Consumer Assessment of Healthcare Providers and Systems survey are becoming increasingly important for hospitals to maintain market share and avoid losing reimbursement. Under the value-based purchasing program, hospitals could be financially penalized for low HCAHPS scores. In addition, hospitals' increased transparency and patients' greater involvement in choosing their hospital will force hospitals to provide a positive experience to attract patients. Here are four strategies hospitals can use to increase HCAHPS scores.

1. Communicate clearly and often. One of the foundations of a positive patient experience is communication — both between providers and patients and among providers. Several questions on the HCAHPS survey address communication. For example, the survey asks patients:

- How often nurses and physicians listened carefully to them.
- How often nurses and physicians explained things in a way they could understand.
- If hospital staff told them what their medicine was for.
- If hospital staff described possible side effects of their medicine.
- If physicians, nurses or other staff discussed whether they would have the help they need after leaving the hospital.
- If they received information in writing about symptoms or health problems to look out for after leaving the hospital.

In a blog post titled "Simultaneously Enhance HCAHPS Scores and Patient Flow," Darin Vercillo, MD, a co-founder and CEO of patient flow software firm Central Logic, wrote, "In medicine, good communication is the action most highly praised by patients and families. 'My nurse explained to me…' and, 'the doctor sat and talked to us…' are phrases associated with high HCAHPS scores. You never see a comment card saying, 'my nurse ran that infusion so well,' or 'my doctor picked the perfect antibiotic.'" In today's healthcare environment, safe, quality care is expected from hospitals; the experience at the hospital may be what differentiates one hospital from another for patients.

Communication tools

There are many tools and tactics hospitals can use to improve their communication with patients. Hospitals should use multiple modes of communication to emphasize important information and help patients remember key instructions. "To reinforce important information to patients, staff should both write instructions and repeat them verbally, giving patients time to respond with questions," says Elizabeth Chabner Thompson, MD, MPH, a patient advocate and founder and CEO of Best Friends for Life Co., which makes products for patients recovering from various conditions.

At South Nassau Communities Hospital in Oceanside, N.Y., each patient's room has whiteboards to help physicians, nurses and staff communicate with patients, according to Ruth Ragusa, RN, vice president of organizational effectiveness and performance improvement at the hospital.

Another tool hospitals can use to ensure effective communication is interpretation services. Providing interpreters for patients who do not speak or understand English is crucial for communicating information about medication and discharge instructions.

Follow-up calls

Hospitals are also conducting follow-up calls to patients after discharge to answer any questions, ensure discharge instructions are followed and solicit feedback on their experience. Zach Silverzweig, a co-founder of healthcare solutions company CipherHealth, says one of the benefits of asking patients about their experience post-discharge is that patients feel the hospital is really listening to and cares about the patient.

2. Collect and act on data. As in most improvement initiatives, lasting improvement in HCAHPS scores requires hospitals to collect, analyze and act on data about the patient experience. At the basic level, hospitals can examine HCAHPS surveys to identify trends and problem areas. However, one of the weaknesses of the HCAHPS survey is its low response rate, according to Mr. Silverzweig.

"You get a lot of squeaky wheels. People who are very satisfied and people who are very unsatisfied want to tell you about their experience." Mr. Silverzweig says hospitals can avoid this issue by communicating with every patient about their experience. A larger response rate will ensure hospitals receive data about universal problems in the patient experience. "You need to get a consensus view of how patients feel," he says. "Understand what changes are important for all patients, because that's what drives the most valuable improvement."

Target specific drivers of satisfaction

Data, whether from HCAHPS surveys, follow-up calls or other tools, can help hospitals determine what is most important for patients experience and then create projects to target these areas. "People think about patient satisfaction as this big, amorphous problem, but if you can think of a few key small micro-projects, you will be able to move the needle," Mr. Silverzweig says.

For example, he says one hospital found through follow-up calls that some patients were complaining that the beds were uncomfortable. As the hospital had recently brought in new beds, it determined staff were not adequately trained on using the beds. After additional staff training, complaints on the comfort of the beds dropped off, according to Mr. Silverzweig.

3. Educate patients. Another key strategy in improving HCAHPS scores is to educate patients throughout their hospital stay. "Start teaching and educating people from the day they come in, making sure they are prepared to take care of themselves at home," Ms. Ragusa says. In addition to speaking with patients one-on-one, Ms. Ragusa says hospitals can educate patients through videos at the bedside and written instructions.

Every interaction with patients is an opportunity to educate patients — about their condition, medication, post-discharge plans and follow-up plans. Patients that understand more about their condition and their care will feel more involved in their care process and less detached.

Educating patients during transitions of care, such as from the hospital to a long-term care facility or to home, is especially important for the patient experience because understanding what to do post-discharge eases patients' anxiety. "A 'cold' discharge process can leave a patient feeling like a number," Dr. Chabner Thompson says. "Empowering the patient with pertinent information and support tools makes a huge difference."

4. Make a positive patient experience part of the culture. Significant, long-term improvement of HCAHPS will depend on the culture of the hospital. Hospitals where leaders emphasize the importance of patient satisfaction and where staff are trained in patient satisfaction strategies will be more successful in projects to improve HCAHPS scores.

Leadership

Developing a strong culture that values the patient experience begins with leadership. "The single most important contributory factor in our success is that the hospital's senior [leaders] embrace and drive service excellence for the organization," says Teresa Williams, RN, MSN/MHA, PhD, vice president and chief quality officer of Franklin, Tenn.-based Capella Healthcare. "They must develop and drive a mature model of accountability that permeates the culture. That culture of service excellence must be continuously nurtured in order

to consistently achieve the strong HCAHPS scores and provide the best care for our patients and communities."

To create a culture that values the patient experience, Ms. Ragusa suggests hospital leaders interact often with the patients. "A key function of leadership is to be accessible to patients and families so that you have first-hand feedback from patients and families directly," she says. "We have all of our management staff making rounds, talking with patients, talking with families, so they're close to what the patients are experiencing."

Training staff to adopt a patient-centric approach to patient care can also help hospitals emphasize the importance of patient satisfaction. "The perspective we always try to take is approach each patient as you would like your family member treated, understanding that [the hospital] may be a common place for us as professionals, but it is a unique situation for patients and families," Ms. Ragusa says. In addition, hospitals should acknowledge that treating patients goes beyond one individual, as treatment also affects the patient's family, according to Ms. Ragusa.

Small changes have big effects

Even small changes in physicians' and staff members' behavior can influence patient satisfaction. For example, Ms. Ragusa says sitting to talk to patients and families instead of standing can give a more positive impression. "Everyone [in the hospital] has so many things to accomplish, and it's easy for patients to feel that they're rushed," she says. "Even something simple like when you go in to speak to a patient, sit down as opposed to standing. It might take the same amount of time, but the impression is not rushed. The impression is that you might have spent more time when really you haven't." ■

Hospital & Health System Transactions

St. Louis-based **Ascension Health** signed a memorandum of understanding with Tulsa, Okla.-based **Marian Health System** to acquire the three regional health systems that comprise Marian Health.

BayCare Health System in Clearwater, Fla., and **Sarasota (Fla.) Memorial Health Care System** are discussing forming a strategic alliance.

Care New England Health System in Providence, R.I., and **Memorial Hospital of Rhode Island** in Pawtucket signed a letter of intent, clearing the first step in their partnership discussions.

Kansas City, Mo.-based **Carondelet Health** acknowledged that discussions to sell **St. Mary's Medical Center** in Blue Springs, Mo., along with **St. Joseph Medical Center** in Kansas City intensified, prompted the Blue Springs community to start a petition against a sale.

Cheyenne (Wyo.) Regional Medical Center will manage **Kimball (Neb.) Health Services.**

Christus St. Michael Health System in Texarkana, Texas, and **Atlanta (Texas) Memorial Hospital** agreed to a merger by signing a 10-year lease agreement.

St. Mary's, Pa.-based **Elk Regional Health System's** board of directors approved and signed an affiliation agreement with **Penn Highlands Healthcare** in DuBois, Pa.

Essentia Health and the **North Pine Area Hospital District's** board signed a three-year agreement for Essentia to continue operating **Essentia Health-Sandstone** (Minn.).

Fairmont (W.Va.) General Hospital is still looking for a strategic partner after a 60-day period of negotiations with **West Virginia United Health System** ended without an official partnership.

HealthPartners in Bloomington, Minn., and **Park Nicollet Health Services** in St. Louis Park, Minn., signed an agreement to unite their organizations and create a comprehensive, integrated healthcare delivery and financing organization.

Henrietta D. Goodall Hospital in Sanford, Maine, received approval from HHS Commissioner Mary Mayhew to join **MaineHealth** System in Portland.

The Rhode Island Superior Court approved New London, Conn.-based **Lawrence & Memorial Hospital's** $69 million bid to acquire **The Westerly (R.I.) Hospital.**

Baton Rouge-based **Louisiana State University Health System** supervisors voted to allow all 10 LSU System hospitals to seek partners to invest in, manage or buy the hospitals.

Michigan Attorney General Bill Schuette approved the $483 million sale of non-profit **Marquette (Mich.) General Hospital** to for-profit **Duke Lifepoint** in Brentwood, Tenn.

Colorado Springs voters agreed to lease **Memorial Health System** in Colorado Springs, Colo., to **University of Colorado Health** in a special election.

Mayo Clinic Health System in Albert Lea, Minn., and Austin, Minn., are planning to merge under the same organization.

Memorial Health University Medical Center in Savannah, Ga., announced a strategic partnership with Winston-Salem, N.C.-based **Novant Health.**

MidMichigan Health and the **University of Michigan Health System** announced plans for a clinical and business affiliation.

The Nueces County Hospital District in Corpus Christi, Texas, approved an agreement to become part of **Christus Spohn Health System** in Corpus Christi.

Pattie A. Clay Regional Medical Center in Richmond, Ky., announced its full membership in **Baptist Health** in Louisville, Ky.

Ontario, Calif.-based **Prime Healthcare Services** signed an asset purchase deal with **Landmark Medical Center** in Woonsocket, R.I., after Boston-based **Steward Health Care System** terminated its agreement to acquire Landmark. Steward said it withdrew from the deal because healthcare parties in Rhode Island and Landmark's special master failed to meet conditions specified in the deal.

Ontario, Calif.-based **Prime Healthcare Services** plans to acquire **Lower Bucks Hospital** in Bristol, Pa.

Queen's Medical Center in Honolulu finalized a deal with Honolulu-based **St. Francis Healthcare System of Hawaii** to acquire and reopen the shuttered **Hawaii Medical Center-West** in Ewa Beach.

Branson, Mo.-based **Skaggs Regional Medical Center's** board of directors and Springfield, Mo.-based **CoxHealth's** trustees agreed to partner.

Boston-based **Steward Health Care System** announced it completed the acquisition of **New England Sinai Hospital** in Stoughton, Mass.

St. Vincent Health in Indianapolis will manage operations of **Monroe Hospital** in Bloomington, Ind.

St. Vincent Health System in Little Rock, Ark., and the **University of Arkansas for Medical Sciences** in Little Rock are exploring a potential affiliation.

Officials at the **University of Louisville (Ky.) Hospital** extended the Sept. 28 request for proposal deadline in their search for a partner.

The Virginia (Minn.) City Council approved the proposed affiliation between **Virginia (Minn.) Regional Medical Center** and Duluth, Minn.-based **Essentia Health.**

Pittsburgh-based **West Penn Allegheny Health System** canceled its $475 million merger with insurer **Highmark**, claiming the payor breached the affiliation agreement.

Officials of **Yale-New Haven (Conn.) Hospital** and the **Hospital of Saint Raphael** in New Haven signed the final closing documents for YNHH to acquire the assets of the HSR.

Hospital & Health System Executive Moves

Chuck Adams, CEO of Royston, Ga.-based Ty Cobb Healthcare System, announced his resignation.

Camille Bash, CPA, was named CFO and vice president of finance of Doctors Community Hospital in Lanham, Md.

Bell Hospital in Ishpeming, Mich., named **Floyd Bounds** as CEO.

Mick Brant, CEO of Grace Cottage Hospital in Townshend, Vt., announced he will leave his post at GCH to become the CEO of Gothenburg (Neb.) Memorial Hospital.

Mindy Burdick, president of Mercy Hospital Ardmore (Okla.), and **Ryan Barnard**, the hospital's COO, both announced their resignation.

Carolyn Caldwell, president and CEO of Centerpoint Medical Center in Independence, Mo., announced she is leaving her position to take a new job in Palm Springs, Calif.

Robert Esker, COO of St. Anthony's Memorial Hospital in Effingham, Ill., announced he will retire at the end of the year.

Winfield, Ill.-based Cadence Health has appointed **Robert Friedberg** as president of Delnor Hospital in Geneva, Ill., and **Brian Lemon** as president of Central DuPage Hospital in Winfield, Ill.

Piedmont Henry Hospital in Stockbridge, Ga., named **Danny Harris**, CPA, as vice president and CFO.

Augusta, Maine-based MaineGeneral Health named **Chuck Hays** as its new CEO effective Jan. 1, 2013.

Jack Hill was named COO and site administrator of The Jewish Hospital in Cincinnati.

Coordinated Health in Allentown, Penn., named **Mark Holtz** as COO.

Dan Hymans, president and CEO, and **Les Whiteaker**, vice president and CFO, of Memorial Medical Center in Ashland, Wis., and its parent company, Regional Enterprises, both announced plans to retire in 2013.

Peter Jennings, CEO of OSF St. Francis Hospital & Medical Group in Escanaba, Mich., announced he plans to retire from the Peoria, Ill.-based OSF Healthcare System, effective April 30, 2013.

Children's Healthcare of Atlanta's COO, **Brett Lee**, resigned.

Catholic Health System in Buffalo, N.Y., extended the employment contract for President and CEO **Joe McDonald** through 2020.

St. Mary's Hospital in Madison, Wis., chose **Kristin McManmon** as its COO.

MultiCare Health System in Tacoma, Wash., named **David Nicewonger** COO of Auburn (Wash.) Medical Center.

Catholic Medical Center in Manchester, N.H., named **Joseph Pepe**, MD, as its new president and CEO.

Auburn, Ind.-based DeKalb Health announced that CEO **Kirk Ray** resigned.

Ken Rivers, CEO of Inland Valley and Rancho Springs Medical Centers in Wildomar and Murrieta, Calif., resigned to take a position as CEO of Hollywood Presbyterian Medical Center in Los Angeles.

Robert Robbins, MD, was named president and CEO of Texas Medical Center in Houston.

Day Kimball Healthcare in Putnam, Conn., named **Donald St. Onge** as its new COO.

Roxane Townsend, MD, was removed as CEO of Baton Rouge-based Louisiana State University Health Care Services Division and was replaced by **Michael Kaiser**, MD, who is now the interim CEO.

Dan Woods, president and CEO of St. Anthony's Memorial Hospital in Effingham, Ill., announced his immediate resignation.

El Camino Hospital in Mountain View, Calif., named **Mike Zdeblick** as its new COO.

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