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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

October 2011 • Vol. 2011 No. 8

Looking Back to Move Ahead: Leading Hospitals Through Fast-Paced Change

By Molly Gamble

Healthcare executives might remember time moving a bit more slowly before March 23, 2010. That was the day President Obama penned his signature, supposedly letter by letter, onto the Patient Protection and Affordable Care Act. The average workday for healthcare or hospital CEOs was probably filled with slightly different concerns or agendas before that

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False Claims Based on Unneeded Procedures: 4 Strategies for Compliance

By Molly Gamble

Federal and state regulators have increased scrutiny around false claims involving medically unnecessary services in recent years. Such claims are costly to Medicare, Medicaid and other payors, and providers are liable under the False Claims Act for these false billing practices. However, medical necessity is not always easy for hospitals to detect. The definition of "necessity" may change depending on the payor, court or provider involved.

By maintaining regular and comprehensive medical audits, hospitals can ensure medical necessity, proper coding and legal compliance.

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Non-Profit Hospitals Taking More Aggressive Stance Toward M&A, But Deals Aren't Always Easy

By Bob Herman

Hospitals, health systems and physician practices are forming partnerships at an accelerated rate, almost as if they were going out of style. For-profit systems are not the only movers and shakers in the merger and acquisition market. While for-profit systems have recently gained a lot of attention for their aggressive acquisition strategies, non-profits are remaining active. Certain strong non-profit systems are actively acquiring other hospitals, while smaller systems and hospitals are merging with physician practices at a growing rate.

Denver-based non-profit Catholic Health Initiatives is currently engaged in a potential merger with the Louisville

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Publisher's Letter

Becker's Hospital Review Annual CEO Strategy Roundtable; CEO and CFO Annual Strategy Webinar; 2012 Becker's Hospital Review Annual Meeting

October Special Issue. We are pleased to share with you the October issue of *Becker's Hospital Review*. This issue includes special coverage of the Annual CEO Strategy Roundtable. The event, which took place this summer in Chicago, brought together four hospital and health system CEOs 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. A special section on the roundtable begins on page 10.

This issue also includes our annual list of 56 Women Hospital and Healthcare Leaders to Know, featuring 56 women who demonstrate outstanding leadership within the hospital and healthcare industry. These women were chosen based on a wide range of critical management and leadership skills, including oversight of hospital or health system operations, financial turnarounds and quality improvement initiatives.

Becker's Hospital Review CEO and CFO Annual Strategy Webinar. We are excited to be hosting an annual webinar on hospital strategy issues for hospital CEOs and CFOs. The "Hospital CEO and CFO Strategy - 2012" webinar will take place on Nov. 8 from 1:00-3:00pm CDT. Listen to CEOs and CFOs of hospital and health systems discuss their key strategy issues and speak on:

- Key priorities
- Advice to aspiring CEOs
- How they spend their time
- Key alignment strategies

The webinar will be moderated by Chuck Lauer, former publisher *Modern Healthcare* magazine and myself. Registration for the event will open soon on www.BeckersHospitalReview.com under "Webinars."

2012 Becker's Hospital Review Annual Meeting. Please save the date for the 2012 Becker's

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BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

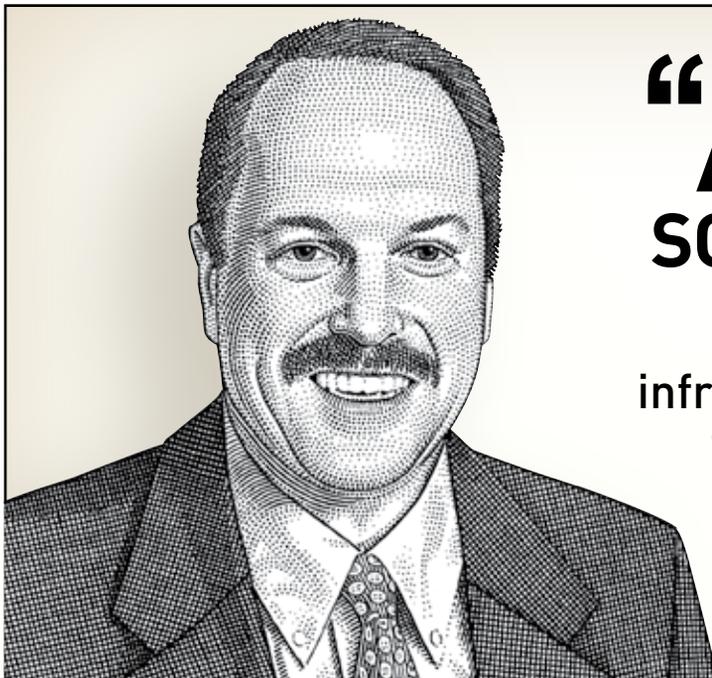
Hospital Review Annual Meeting — ACOs, Physician-Hospital Integration, Improving Profits and Key Specialties, taking place May 17-18, 2012 at the Hotel Allegro in Chicago. We have prominent keynote speakers planned for the event, including Bob Woodward, Coach Mike Ditka and Suzy Welch.

Should you have any questions or we could be of help in any manner, please contact me at sbecker@beckershealthcare.com or call me at (312)750-6016.

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



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Looking Back to Move Ahead: Leading Hospitals Through Fast-Paced Change (continued from page 1)

moment. Since then, though, the industry has been flung into fast motion to accommodate the policy changes mandated in that 2,700 page bill along with its larger overarching themes that are shaping modern-day healthcare.

“Over the past 6-12 months, changes induced by healthcare reform have added to an already packed CEO agenda,” says Russ Richmond, MD, CEO of the McKinsey Hospital Institute, part of the global McKinsey Healthcare practice, which serves seven of the 10 largest healthcare systems in the country, among other clients. “For some CEOs these additional pressures are new territory, requiring new skills and behaviors.”

Throughout the numerous conversations this publication has held with healthcare executives, a certain phrase seems to pop up frequently: the pace of change. Many leaders speak to how it has accelerated in the past year and a half, influencing hospitals' strategy and executives' personal leadership style. Here, we analyze the greatest sources of pressure facing today's CEOs and examine how history can help leaders find their footing.

Effects on hospitals' strategy

The healthcare industry is only in the early innings of the game since PPACA provisions will be implemented throughout 2015. Currently, 50 of healthcare reform's 92 provisions are in effect, though the greatest sources of pressure on the hospital CEO is not directly related to any one provision. Rapid consolidation in the industry is leaving many CEOs with some difficult choices: remain independent, partner with another provider or pursue an accountable care organization, in addition to a few other options.

During the second quarter of 2011, the healthcare sector posted 243 merger and acquisition deals worth a combined \$73.7 billion — a 6 percent increase in volume of deals over the first quarter of 2011 and a 3 percent increase over the same quarter a year ago, according to Irving Levin Associates. Even if hospitals didn't foresee an affiliation in their strategic plan, they may find themselves on the defense to protect market share.

“All of a sudden, with a significant amount of anxiety and intensity, CEOs have to think through different partnership scenarios or grapple with the decision of remaining independent. We have not seen this level of deal velocity — especially with community and regional hospitals — in the last 10-15 years,” says Dr. Richmond. Mergers and acquisitions are now approached from a proactive rather than reactive angle, as CEOs work to ensure they have a seat at the table when it comes to deals with both ambulatory care and acute-care providers in their local market. As hospitals consolidate, the highest-level CEOs find themselves overseeing larger and more complex organization than in the past, and in many cases they are responsible for many sites of care beyond acute-care facilities.

There are significant pressures exerted from the hospital's internal operations as well. The combination of PPACA-mandated payment reductions, additional likely cuts to Medicare and the rise of risk-based reimbursement stresses the need for operational efficiency and cost reductions in the day-to-day. “In order to maintain some type of margin, hospital efficiency is becoming even more critical than it has ever been,” says Dr. Richmond.

As a result of these operational pressures, CEOs are delving deeper into initiatives that they may have traditionally delegated. CEOs have always been familiar with cost-side programs, but they are now becoming in-

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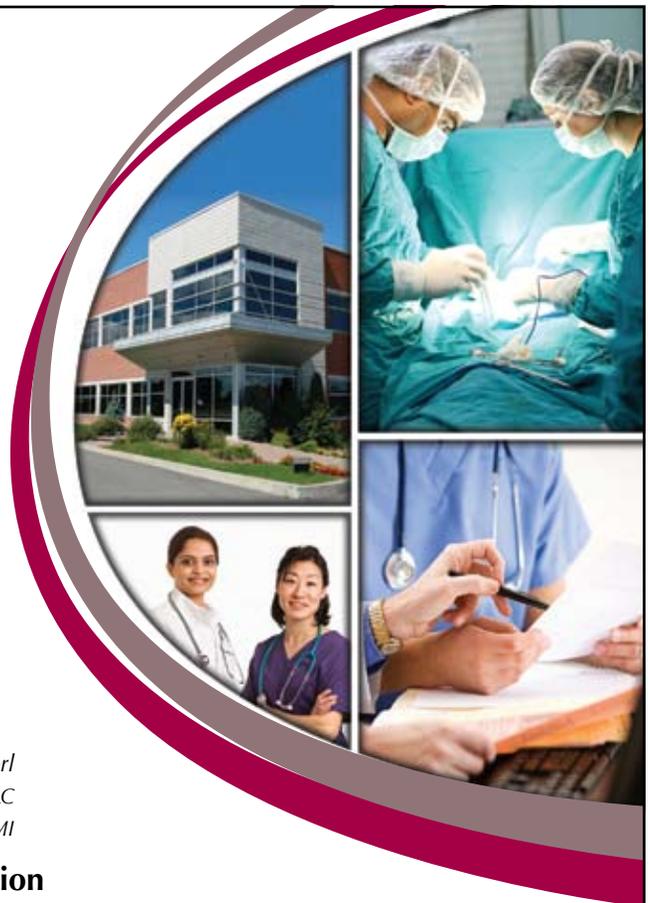
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volved in greater detail. "We are seeing CEOs engage directly in detailed cost-driven decision making. For instance, we are seeing a stronger CEO voice in labor and supplier expense management, as well as physician practice variation," says Dr. Richmond.

Relying on experience and history lessons

A handful of hospital leaders have completed prestigious training or other formal education before arriving at their current position. Still, when it comes to providing the necessary leadership under healthcare reform, nothing is more valuable than hands-on experience and a solid grasp of history. Craig Garner, JD, an attorney and adjunct professor of law at Pepperdine University in Malibu, Calif., as well as a former hospital CEO, believes there are very few programs designed to train healthcare management in today's current climate of reform.

"Even the programs presently in existence, such as the American College of Healthcare Executives, have yet to develop a formal or comprehensive discipline on healthcare reform. Instead, healthcare leaders must rely upon past experience, practical acumen, and a little bit of his-

tory in responding to these swift and sweeping changes," says Mr. Garner.

Indeed, an executive's understanding of healthcare history can play a vital role in how well he or she approaches change. Many of the provisions within healthcare had some form of direct or indirect implementation previously, and a firm understanding of this history can help leaders with modern day implementation. For instance, bundled payments are not new to healthcare. The Department of Health and Human Services announced a new bundled payment initiative in late August, but the model's roots go back as early as 1984 when a heart hospital in Texas began charging flat fees for cardiovascular surgeries.

"No matter how 'up-to-speed' a healthcare CEO may be on the present-day regulations and changes, nothing replaces the benefits of a solid understanding of historical, critical foundational changes in healthcare," says Mr. Garner. Other initiatives that played out in healthcare history also required a significant amount of change, such as the creation of diagnosis-related groups in 1982 and the Emergency Medical Treatment and Active Labor Act, or EMTALA, in 1986.

DRGs and EMTALA are just two initiatives that had major repercussions on hospitals' operations, finances and physicians. They can also be linked to contemporary themes in PPACA, such as new payment methods or expanded coverage. "DRGs created a whole new way to pay. Does that sound familiar?" says Mr. Garner. "How familiar today's healthcare leaders are with historical tenets in healthcare reform will be an enormous asset as they formulate appropriate plans of action to keep up with the changes." ■

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Becker's Hospital Review

Annual CEO Strategy Roundtable

Becker's Hospital Review Annual CEO Strategy Roundtable

Becker's Hospital Review hosted its Hospital Strategy Roundtable this summer at the Four Seasons Hotel in Chicago, bringing together nine 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.

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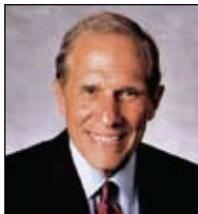
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Chuck Lauer: The one thing you can say about healthcare is it's continually changing every day. It's the most dynamic industry in the world. What an exciting time to be in healthcare. I've never seen quite the confusion and the turmoil that's going on in the minds of so many people in the industry. The first question I'll pose for you all is a pretty simple one: What are your priorities right now? In terms of the things you go about in your day-to-day activities, what are the things that are really important to you as you hit the office?

Stephen Mansfield: I'll mention three. I think it's a long list, and what's my priority today could be different tomorrow. For our organization it's passionately communicating the why, what and how of healthcare reform to all of our organizational stakeholders. I'm still struck by the challenge to get everybody comfortable or at the same place [in understanding] the why, what and how of healthcare reform. That's a priority for me. I think it's a role I can't delegate to anyone else. It's a CEO question. I think there's a lot of discussion about what healthcare reform is and how we plan to accomplish it, but not nearly as much — and especially in our sector — about the why.

Secondly, I would say I find myself spending a lot of my time with strategy....trying to have a relevant strategic plan with all the uncertainty is probably as challenging as it's ever been in my four-decade career. Within all of that, I find myself struggling

with organizational pacing. We know what we want to do, we know what our priorities are, but we physically can't get it all done so we have to revisit periodically about the pace.

Third, I'd say all stakeholder groups are important but I find myself with a lot more meetings and a lot more complexities around medical staff issues. It's always been a major part about what we do, but the complexity and the number of times now I'm being asked, "What should I do?" by physicians is a new phenomenon for me.

Mark Newton: Well, there are multiple priorities, but the things I'm most concerned about are what I call, in healthcare reform, the 'unintended consequences.' My own perspective of this is that the consumer is not engaged in healthcare reform, and there's a huge void that is looming out there where the average patient has no concept of what's going to hit them and their responsibilities. I'm immensely worried about the lack of attention being paid to the public consumer. I also believe that the legislators have no concept how to implement this and we're certainly scrambling as well. I'm just trying to figure out our role and my role in addressing or trying to get some clarity around all these things that are uncontrollable, and articulate the consequences so at least members of the public and legislators know. It's unfortunate hospitals have really been put in the role of explaining that.



Chuck Lauer moderates the roundtable, while Alan Channing looks on

Richard Miller: I think everything that Steve and Mark stated is spot on. I think the thing I try to work on regularly is talent development for people in my organization. I think if you develop talent, it gives you the ability to maneuver and to grow quickly and in a proper way. So if you find people that are very talented, to me it's the most important thing you can do, and that's probably true in any industry, but in healthcare today I think it's especially important.

Secondly, I think [hospitals] are the ones that will eventually be required to deal with the health of our communities. So how are healthcare systems in the future going to be able to care for the public and help them with chronic disease issues? I see that as something for which we are preparing. I think one of the major challenges of any healthcare organization today is the transition from one economic system (fee-for-service) to the assumption of risk in a population-based economic model. In my opinion, the economics aren't there yet for healthcare to totally move to population-based management, so to speak. So, you're trying to prepare for that future, but you can't turn that light switch on yet, because economically you can't afford to completely move in that direction.

Finally, the physician component is a big issue as well. Physicians are looking for partnerships and employment; as we've seen in our part of the country, the wave of physicians coming to us for employment is overwhelming. We can't keep up with it at this point in time, so it creates a dilemma for us economically.

Alan Channing: When I meet with our new employees, I talk about what an exciting time it is to be in healthcare. It sort of reminds me of the old Chinese curse, "May you live in in-

teresting times." When you look at [Sinai's] payor mix, we're about 60 percent Medicaid, 20 percent Medicare, 15 percent uninsured and 5 percent everything else. So, we're excited about healthcare reform because at least two-thirds

of that 15 percent are going to be covered, and we think we're uniquely positioned to care for that population. What you can control and what you can't control, though, are the things I struggle with.

Chuck Lauer: One of the paramount things that has come out of just distilling these comments a little bit is that nearly all of you have mentioned physicians. I'm intrigued by what kind of models you're setting up for the physicians in terms of working with them. What kind of models are you exploring? I think this is going to be a whole new movement that's going to be fascinating to observe, and it's a tough one for each of you who are in the business of running hospitals.

Richard Miller: I think the approach is to use a myriad of strategies on the physician front. We have an acquisition/employment strategy for doctors, primarily primary care. We're very invested in primary care in our community but specialty now, too. It's amazing how many cardiologists now are looking for employment. A second strategy, with our surgeons, is joint venture. We have five sur-

gical centers that have been very successful for us. That part of our business has actually grown. We're looking at some co-management models as well, particularly for the cardiologists. Then, we have our independent physicians [who] want to stay independent. We support their independence. From my perspective, you have to have a multiple tiered perspective to deal with everybody's needs. Five years ago I didn't see hardly any of this type of activity, now it's an onslaught and you have to be prepared for it. The problem is the economics are tough.

Mark Newton: For Swedish Covenant, it's a combination of independence and employment combined with training programs for primary care physicians in order to form a "farm team" so that people who understand the culture and understand the community stay with the organization. It's so much easier to train someone for four years and bring them into a delivery system in more a formal way [than it is to recruit already practicing physicians]. Over the last couple of years, this has been a huge piece of our overall strategy. We do have that creative tension between employed and independent [physicians], and it's like a teeter totter managing that balance. You really do need to be engaged in [multiple strategies] concurrently, you can't just take one strategy or tactic and make it work.

I think one of the major challenges of any healthcare organization today is the transition from one economic system (fee-for-service) to the assumption of risk in a population-based economic model.

Chuck Lauer: Steve, you're in a hotbed of physicians in Dallas. You've got a lot of action going on.

Stephen Mansfield: It's the wild, wild West. As you all said earlier, I do think you have to be pluralist in your approach. We have everything on a continuum from shared ownership in two of our hospitals to medical directorship, which I guess are probably the most benign. I was reading that almost 50 percent of physicians are employed or in relationships with hospitals, and almost 76 get money from a hospital in some form or fashion. So, the vast majority of physicians are in some kind of financial relationship along the continuum with hospitals.

I would reflect maybe on two things. I try every three years to do about 60-80 interviews with different members of our medical staff. This past time, last fall, I met with a group of our employed physicians and I initially dreaded the meeting because I thought it could be a gripe session. But, I was so impressed by how engaged they were in the things I was interested in. As I reflected upon why, I think one is that Texas is

a corporate practice of medicine state, so we're forced into governance structures that allow physicians to self-govern, as you would want to do anyway. And, the structure that's been in place at Methodist since long before I arrived there really does allow the doctors to feel like they're captain of the ship, because they really are.

Scott Becker: I've heard a couple of you say it's about a pluralistic strategy, not a one-size-fits-all [approach]. But, if you look at three or four different strategies — employment, co-management, joint ventures or other types of some financial relationship — do you have to have a core strategy for physician alignment?

Stephen Mansfield: Well, for us, we're spending much of our energy and a fair amount of our money right now on trying to put together an acceptable clinical integration strategy, because most of our medical staff members are still independent. We want enough scale on the primary care side that they pay attention to us.

physicians. I have calendars that are totally blocked out for private lunches with physicians, and I have four physician liaisons who are out in marketplace. I've got a meeting at 8:30 am on Monday for an hour to talk about physician strategy for the week. And it's all related to communication, translated to a very fast, real-time response. So the structural concept of employment, joint ventures and training are all superseded by very aggressive, very tight communication.

Scott Becker: In terms of the constant communication and engagement, is this done by the CEO directly versus lieutenants of yours?

Mark Newton: It's, right now, consuming probably 40 percent of my time.

Richard Miller: Most of the physicians want to talk to the CEO.

Chuck Lauer: They want to talk to the boss. They want to talk to the top guy. Andrew, do you have some reflections?

alignment from the ASC setting and bringing that to a hospital surgery department.

We use a variety of models with our health system partners, which underscores the importance of recruiting and developing highly talented leaders. You have to have very sophisticated thinkers that can draft different strategies by specialty and by geography. Our partners and [SCA] try to be very strategic.

Chuck Lauer: Alan, any thoughts around the issue of physicians?

Alan Channing: I was actually just thinking this is the one area where I don't envy the rest of you. I've been in that seat and understand the pressures dealing with the medical staff and trying to do the things all of you have described. We're in a very unique circumstance; nobody wants to be in practice where the market is primarily Medicaid. So, I employ my physicians, and for first time in my rich career when I go to medical staff meeting everybody is well-behaved. It's just amazing. Now, having said that, there is obviously some tension. I employ specialists, primarily because of teaching and trauma programs. We really function as a referral center for safety-hospitals on the West Side of Chicago. So where does my primary care support come from? It comes from a federally qualified healthcare clinic, which layers a whole different dynamic in terms of relationships.

Scott Becker: Mark, you mentioned spending 40 percent of your time on physician relationships. How much time do the rest of you spend on hospital-physician relationships?

Stephen Mansfield: I don't spend 40 percent of my time, but I have seven hospital presidents that do a wonderful job, and I really expect them to be well-known and to be very active listeners and attuned to their respective medical staffs. You have to be careful not to usurp [the individual hospital presidents], otherwise you become the only one who can give them an answer.

Richard Miller: I don't know if it's 30 percent, but most of the time I spend might not be directly with physicians, but I spend a lot of time on the physician strategy front. My early and late day — dinners and breakfasts — is usually spent with physicians. The COOs for each hospital deal with the medical staff issues, and I deal more with the strategic issues.

Chuck Lauer: Jim, how was the changing dynamic between physicians and hospitals affected your company's role as a supplier?

Jim Abrams: From our perspective, we're seeing way more of our discussions taking place with clinicians, such as the chief medical or chief nursing officer. Frankly, if the culture of improving quality doesn't start with the C-suite, including the CMO and CNO, it's not going to happen. A very significant amount of leadership

Stephen Mansfield discusses physician alignment at the Annual CEO Strategy Roundtable



Our strategy for independent physicians is to bring them together in clinical integration model that allows us to load the bank based on performance metrics and distribute out of the bank based on quality metrics, and that's oversimplified, but that is something I want. We're trying to figure out how to get all of our independent physicians aligned with us in a meaningful way.

Mark Newton: When reflecting on what our core strategy is for physicians, I go back to communication. We've established a board committee specifically on physician relationships, so governance is deeply engaged. I have a very disciplined structure in terms of business rounding through roundtable-like conversations with phy-

Andrew Hayek: This all resonates. The thing that we spend a lot of time on in each market with each of our health system partners is the appropriate strategy for that market and the strategies for each sub-segment of the market. There might be a core area that our health system partners is trying to penetrate into, and there are different strategies for that area for different physician specialties — primary care versus cardiologists versus surgeons, etc. Of course, when you get to surgeons we craft strategies in the market that are different by specialty and by area, and sometimes that strategy includes co-management with hospital departments. We've seen some great success when we align financial incentives for surgeons in the hospital setting, mimicking some of the same

at Medline now is spent on high-level clinical discussions, because improving outcomes is what we've been tasked with under healthcare reform, or doing our part of the process anyway.

Chuck Lauer: Is it silly to ask if the salaries paid to physicians in an employed model are sustainable?

Mark Newton: Right now [this is a] scarcity premium. At some point, that premium will go away. The more looming issues are the cuts in graduate medical education; that's very concerning for hospitals that use training as a way to attract physicians.

Richard Miller: I think it depends on the market. Employment is becoming a defensive strategy in a lot of systems. If the strategy is completely defensive and not part of an overall growth strategy, the cost will become overwhelming.

The time commitment required compared to when I got into this business years ago is much different than it is today. It's every night of every week and weekends. And, it's not only the time commitment; it's the pressure and complexity of the work.

Stephen Mansfield: It strikes me that if healthcare reform is successful in keeping more chronically ill care out of the hospital, that also largely means keeping it away from the specialists, those that cut and do procedures. I have to think there is a point in time coming given that there is such a disparity between some of the high-end specialist salaries and primary care salaries will move closer. I don't see primary care salaries going down in our market, I see them going up.

Scott Becker: Andrew, from what you've observed, what's your sense on where physician employment is going?

Andrew Hayek: From what I'm seeing, primary care and cardiology are moving the fastest. I think the surgeons are quite different. There are some groups that are seeking employment, but I'd say that's the exception. At the same time, a large segment of surgeons are interested in some form of alignment: medical directorships, co-management agreements or joint ventures. I do see a lot of reticence from surgeons on the full employment model.

Chuck Lauer: This talk of outpatient joint ventures brought to my mind the growing shift of inpatient care to an outpatient setting. How will the role of hospitals change given this?

Richard Miller: Surgery will go significantly more outpatient. We know that; we see that. To me, if you're going to partner, the time to partner with doctors and surgeons around outpatient is

now. Frankly, it's a pretty lucrative business — in orthopedics extremely so. It's something you want to really be thinking about if you're not doing.

Scott Becker: Are you all seeing a decrease in total surgeries? I know we've all seen reports suggesting this recently, in part because of the lagging economy.

Stephen Mansfield: I know across our market and as I talk to people across the country, I think elective surgery is down related to the economy.

Andrew Hayek: What I would add to the economy is the growth in the pervasiveness of high-deductible plans, and we don't see that trend reversing when the economy recovers. A deductible of two thousand dollars or more dissuades a segment of people from getting certain types of care. Our guess is that it will be a flat-ish market for quite some time.

Richard Miller: I think hospitals really should include an outpatient strategy as a major part of their overall strategy because that's where it's going.

Chuck Lauer: So what are the unintended consequences of that?

Stephen Mansfield: I think one of the consequences is there is going to be a lot of new competition in the outpatient space, because unlike the large brick and mortar costs needed for entry to inpatient care, that's comparatively less expensive. So, you have Walgreens and others I wouldn't really consider a competitor today that may competitors in the years to come.

Mark Newton: I would say we're seeing a very steady increase of 2-3 percent growth on the outpatient side and probably a light decrease on the inpatient side. It takes about six outpatient visits to replicate one inpatient in terms of revenues and contribution margins.

Scott Becker: Six outpatient episodes of some sort to make up for one inpatient. And you've got just this intense competition on the outpatient side. That's just got to be a challenging spot.

Mark Newton: That's one of the reasons you want to have employment strategy with physicians.

Jim Abrams: I think eventually the hospital is going to be the lynchpin in the community. Everyone's going to come to the hospital because they're going to get incentivized to reduce that re-admission rate. Once that really hits and the money becomes significant, I think we'll begin to see hospitals choose outpatient partners even more strategically than they probably already do now.

Chuck Lauer: I want to turn the conversation to another big challenge for health systems right now — health IT. How much are you spending on IT now and how do you feel about IT?



Andrew Hayek discusses physician alignment strategy



Richard Miller at the Annual CEO Strategy Roundtable event

Stephen Mansfield: I'll tell you every day IT is a frustration to me because of the disparate systems. Technologically, we do not have what I know we're going to need to have. It's not what I'm spending today, it's that I know I have to come back and spend it again. I think having an effective EHR that gives you actionable data that impacts quality at the bedside is like unicorn... Everybody can describe it but no one has really seen one. Health information exchanges and cloud technology may help some, but until someone can take all of these disparate systems and get data in one place that has a common vernacular and can give data back to clinicians and others at the bedside in a way that can give them real-time information to improve performance — then I'm frustrated with it. I don't see an end to that imminently.

Kristian Werling: To add to Steve's point on the data not being used, I recently attended the TechWeek Expo here in Chicago and the keynote address was by Anesh Chopra, chief technology officer of the United States. In his address, he told the attendees that if they wanted to make a billion dollars, they should look beyond creating the next Groupon and instead try to find a way to take the pile of data from health information technology and use it. His message was no one is doing that well now, and he really encouraged this huge room full of entrepreneurs and techies that this is the next threshold of opportunity.

Chuck Lauer: Very interesting. How about the rest of you? What are you all doing in terms of IT spend?

Richard Miller: Our spend in six years has been around \$175 million and that includes the system, infrastructure, acute, outpatient and administration. It's a big spend and I'm still trying

to figure out the overall return on investment for us. For me, the ROI is improved clinical quality and safety. At the end of the day, that's what we're measuring and I want to see that happen. I think the disparate systems are the critical issue. I told my CIO this year before I do another spend we're going to fix that. We have to fix that because we are wasting a lot of clinician time and energy on flow of information.

Mark Newton: We're at Stage 6 [of EHR implementation] and have been for a good number of years. I pretty much target about 10 percent of capital expenditure on IT total. We try to stay with just one system and are an alpha site for our HIE. We move very predictably, but I'm not picking up the pace. One of the observations I would add is I actually caution our independent physicians to go very slowly on an EMR. We're constantly telling physicians, 'Why are you putting a \$25,000 server room into your office? Who's maintaining that?'

Richard Miller: To add to that, it's not only the IT piece, it's the integration of clinical technology into information technology. There's a lot of moving parts. But in saying all this, I must say, it's a must-spend. From the information perspective, I think it's something all hospitals are going to invest in.

Scott Becker: How do your systems deal with integrating the various systems used by your physicians?

Stephen Mansfield: What we've done, which has been a differentiating issue for us, is that we've said if you want to be employed by us, then you have to get on our system. We help with the cost of it. The advantage is once everybody gets on it and uses it you have standardized processes that are awesome, but everyone is coming from a different place and the productivity impact of

having them go from how they've always done it to how they have to do it is challenging. We're having to patch around that with our reimbursement formula, frankly. The physicians do say though that because they're charting is so much better, their billing per case goes up. But, when you put that together with the lost productivity, that's still a negative that we're having to offset. Not bad, but a bit.

Scott Becker: Is that a temporary thing that they're going through?

Stephen Mansfield: We hope so.

Richard Miller: The other issue is the fact that many physicians today are splitter physicians. They go to a number of hospitals, and there are different systems in every hospital. We demanded that our physician base learn our system, but if you multiply that by three or four of five area hospitals, I feel sorry for the physician in that case. It's very difficult.

Stephen Mansfield: It's a tough issue. I agree that an opportunity for an EHR system that truly impacts quality will be available, but I think it's just going to take some time. But, I don't think anyone would advocate not investing in IT. You have to do it, but you have to know more investment is probably going to be necessary in future iterations.

Alan Channing: When you go back to physician relationships, this [HIT] is the one area I've had them knocking on my door. They want to know, 'How will I have to change my practice to make this work for me?' Speaking of scarce resources, there's not enough talent out there. There's not enough IT educators that can speak the language the physicians understand.

Chuck Lauer: I'd like to get into another topic. I'm always taken with the quality and caliber of people running our nation's hospitals. It's a very tough job. One of the things I have seen I guess in last 2-4 years is how mentoring has virtually disappeared from the stage. The time element seems to be the constraint. You just don't have the time any longer.

Stephen Mansfield: Going back in my own career, I never was in an official mentoring program but had wonderful mentors, but the pace was so different then than it is now. Young women and men considering a health-care career and already in healthcare do come to try and talk, and I try to honor as many as I can, but I can't honor them all. It disappoints me in myself, because I think giving back is a part of our jobs. You just get to the point you're physically and mentally exhausted and can't squeeze everything in. I've never worked like this in my life. I think mentoring now is more on the fly — people watching what you do. To reflect on another comment, I was talking with a recruiter for a senior level position recently and I said to him, 'I know every generation

probably says this, but is there a generation behind us that is willing to do this job? Intellectually I know they're smart or smarter, but are they going to want to put in this kind of effort?' He said to me, 'Steve, this is a crisis. And I run into it every week more than the week before as I'm trying to recruit executives.' So, it's a dilemma. It's tough. I cannot put the time into mentoring I wish I could.

Richard Miller: I have to agree. The time commitment required compared to when I got into this business years ago is much different than it is today. It's every night of every week and weekends. And, it's not only the time commitment; it's the pressure and complexity of the work. It's a much different business than when I started. It's fully deregulated now, and I think a lot of people struggle with the fact that you're competing. It's a business. That takes a very different mindset than when hospitals were cost reimbursed.

Scott Becker: To this point of talent management and mentoring, Krist holds an MBA from Kellogg School of Management at Northwestern University. I'd be interested to hear his thoughts on this issue.

Kristian Werling: I don't think a mentor necessarily has to spend a ton of time sitting down and talking about certain things, but it's more about getting promising talent in front of key people and involved in key events. When I work with hospital CEOs now, it seems the great ones have a potential future leader by their side for physician negotiations, for supplier negotiations. That's the kind of mentoring I'm seeing today.

Mark Newton: There's no question there's intense pressure and it's very easy to get inundated with all of the different things that are [thrown] at you. But, I've really had great success from hiring people from other industries. I wasn't trained to be a hospital CEO. Having worked in airlines and hospital supply and international business, I find great success from bringing people in from different industries. They are marvelous, and they learn incredibly quickly. I don't go back to the typical intern route. I wouldn't say it's antiquated, but I'd say it's good to spice the organization up with talent that comes in with a different perspective. When I need a physician liaison, for example, I go to a sales person. We teach them a little bit about healthcare, and boy do they get it.

Scott Becker: And, that's the key. You find great, really bright people and spend a lot of time on recruiting. Employees can find their way very quickly.

Richard Miller: I actually spend a lot of time looking for talent in the middle of our organization. We found a young HR person that today runs our physician business. He's talented and he knows what to do and he does it well.

Having worked in airlines and hospital supply and international business, I find great success from bringing people in from different industries.

Mark Newton: We had an Olympic-ranked swimmer running the aquatics program at our fitness center who now oversees implant purchasing. Within six months, I can't begin to tell you how much cost he's driven out of the organization. The other thing I'd say is I spend a lot of time trying to model more business-driven behaviors and that corporate mindset that can sometimes be foreign in healthcare.

Scott Becker: What do you all have in terms of talent processes?

Richard Miller: We have three what we call 'best people review meetings' a year, where we evaluate the performance of our management team, and I sit in every one of those meetings. We group our managers into three categories: top talent, valued contributor and needs improvement. That's really how we mine top talent in the organization. About 65-70 percent fit into that middle category. I'm looking at people now edging toward top talent or in top talent and thinking about what their future roles will be in our organization.

We've learned every goal needs to have a measure, and we've learned that from the private industry. It's got to be measurable. If it's not measurable, we go back. The other thing we try to do: we don't talk about variance. That doesn't work in our organization. We want to know what will fix it and what's the timeline around the fix.

Chuck Lauer: To bring our discussion to a close, I would like to ask each of you, are you happy you chose healthcare as a career?

Stephen Mansfield: I'm happy. It's always been a blend of ministry and a job for me, personally. It was from the very beginning and it is still today. The ministry aspect has changed, and now I find myself as migrating to feeling like the most important thing I can do to make a difference is to communicate a message of hope and optimism and encouragement to all our employees and stakeholders. The times are so difficult and so uncertain and the complexity is so high, but yet we're in the miracle business. I mean, how many people get to work in the miracle business everyday? I think the message a CEO can give to their organization in this time of uncertainty is to make sure you pay attention to why, what and how as you deliver an optimistic story about your organization and the future. [That] is very gratifying to me. So, yes, I'm delighted to have chosen it, and I wouldn't make the decision differently if I could go back.

Richard Miller: I agree. I still love what I do. It's more of a vocation than it is work to me, and I think the key is to stay focused on why you're here. You're here for the patient. I'm a patient advocate through and through. To me, it's about the patient consistently. You have to go back to make sure the patient care is optimized. To, me though,



Mark Newton
at the Annual
CEO Strategy
Roundtable event

there's the balance with the family too. I have to consider how long I can do this. I know I like to do this, but I have to consider my family too.

Alan Channing: Well, I'm a 60s kid. I grew up when we all believed we could make a difference in world and I still believe that. As to what Steve and Richard said — I can use different words and say exact same thing — to establish environment where the people I have the pleasure to work with see a difference in people's lives and see a future and to help them move in that direction is incredibly rewarding. There were times in my career where I thought I'd do something different, so I'd look around, but nothing came close to allowing me to influence people's lives in such a deep and personal way.

Mark Newton: The thing I most enjoy are the stories of how people in my organization have impacted and changed someone's life. It's so much fun just to hear that, and it puts everything else to rest. The other thing that's really fun is that when you tell people working in your organization that it's ok if you take your personal passion and combine it with a professional passion. I get to give them that freedom and tell them that that's exactly what we want them to do and see how they do that.

Jim Abrams: I will add I think we're all in a collective position to do good for other people. Every day you look at the number of people who are needing care, and as Baby Boomers age, we're all going to be in a place where we or some loved one needs care. I feel like if we play our

part right, we can truly impact care.

Mark Newton: One other dimension for me that is very motivating personally is the concept of justice. I've often questioned why some people, based on where they grow up, gets access to care differently than others. Anything I can do to address that idea of inequity or injustice is very motivating.

Chuck Lauer: Thank you all for your valuable insights. Scott, any closing comments?

Scott Becker: I would just say this has been fascinating, and healthcare is just an absolutely fascinating industry. It just continues to evolve. Being a hospital CEO is a 24/7 job like no other. To be a CEO, you've got to love it. It's just an amazing thing. Thank you all again for talking with us. ■

Big Pain or Big Gain? Important Factors for Hospitals Considering Partnerships With Retail Clinics

By Sabrina Rodak

Hospitals and health systems partnering with retail clinics, such as CVS' MinuteClinic and Walgreens' Take Care Clinic, is a growing trend. Recently, New Orleans-based Louisiana State University Health Sciences Center and the LSU Healthcare Network partnered with area Take Care Clinics and Detroit-based Henry Ford Health System partnered with MinuteClinics. Although the partnerships with health systems are relatively new, retail clinics have been growing increasingly common for years. As of July 1, 2011 there were 1,251 retail clinics in the United States, an increase of 74 percent from the previous year, according to a July 2011 Merchant Medicine report.

There are a variety of potential benefits motivating partnerships between health systems and retail clinics, including greater access to care and lower costs. However, hospitals and health systems still face challenges, such as relying on a retail-based entity to deliver healthcare services. Experts discuss these pros and cons of hospital-retail clinic relationships and what factors healthcare leaders should consider when thinking about forming such a relationship.

Access

One of the biggest motivating factors for hospitals and health systems to partner with retail clinics is to increase patients' access to care. "Thirty-two million more Americans will be looking for healthcare under healthcare reform," says Fred Campobasso, managing director of consulting firm Navigant.

This influx of new patients will compound an already overburdened system. Some experts point to a shortage of physicians, while others say the true culprit is administrative demands on physicians' time. "Our belief is that we don't have as critical a shortage of primary care as many people seem to believe. The real problem is that we've got primary care doctors in their offices tied up doing things they don't need to do," says Howard J. Peterson, managing partner of the management consulting firm TRG Healthcare. Retail clinics could thus provide an additional resource for patients with only minor health issues, freeing up primary care providers' time for sicker patients.

Coordinated care

Retail clinics' partnerships with hospitals and health systems allows for greater coordinated care. "[This trend] is in large measure about defragmenting healthcare. Depending on the nature of the relationship, the partners can link medical records, use common clinical-quality protocols and coordinate plans for follow-up care, all of which are intended to produce better outcomes," says Marc Malloy, CEO of the Renaissance Medical Management Company. More coordinated care can improve the quality of care by providing services to patients in the right place at the right time. "In a more coordinated world, we're going to have an evolution of services and patient experience in terms of who [patients] are interacting with for the care they need," says Gabe Weissman, external communications manager for Take Care Health Systems.

Electronic medical records form the basis of how retail clinics and providers can exchange information to avoid duplication of services and to better care for patients. "Technology has become the enabler to be able to move healthcare outside of the medical setting," says Virginia Cardin, DrPH, senior healthcare consultant with Frost & Sullivan. One of the challenges of coordinating care is aligning different electronic systems for sharing data. "It is very important for the industry to figure out standardized ways of communicating between disparate providers and sharing information in real time," says Ron Weinert, Walgreens' vice president of health systems services. He says Walgreens is working to standardize its own processes to share results from Take Care Clinics and receive data from providers.

Hospitals and health systems also benefit from greater coordinated care with retail clinics in patient referrals. "Having a relationship with a clinic means that if there is a medical need that cannot be treated at the retail clinic, there is an established relationship and referral pattern, which benefits the hospital, the clinic and the patient," Mr. Malloy says.

Medication compliance

As part of this enhanced coordination of care, retail clinics can increase

patients' medication compliance. "One of the challenges hospitals have is effectively transitioning the patient back to the community," Mr. Weinert says. He says Walgreens is helping improve patients' compliance by establishing pharmacies in hospitals' lobbies, allowing easy access for patients. In addition, a recent agreement between Chicago-based Northwestern Memorial Physicians Group and Walgreens includes a program to educate patients about their disease and medication and to share patients' medication information between primary care providers and pharmacists. Improved medication compliance is beneficial not only for individual patients' health, but also for the healthcare system because it can reduce readmissions due to noncompliance.

Marketing

Hospitals and health systems may also partner with retail clinics to increase brand recognition. Being associated with well-known names like CVS and Walgreens and the retail clinic model can help hospitals "gain a reputation for treating the well, not just the sick," Mr. Campobasso says. As part of a hospital's outreach to the community, retail clinics can thus help achieve one of healthcare reform's goals of improving the health of a population, according to Mr. Campobasso.

Cost

The rising cost of healthcare is another motivating factor for hospitals and health systems to partner with retail clinics. One way retail clinics save costs is by providing an alternative to an emergency room. "Enormous cost savings can be driven by diverting inappropriate ER utilization into the retail clinic environment," says Mr. Weissman. Reducing inappropriate emergency department use lowers the cost to patients because those with non-emergent cases can access the less expensive retail clinic. Dr. Cardin, who has researched these partnerships, says the average cost per visit is \$50-\$65. Lowering unnecessary ED use also reduces the cost to the system because it can reserve resources for patients who truly need them. Although in general an increase in patients drives revenue, an overtaxed emergency room may force hospitals to use costly resources, including staff time, on patients who are actually non-emergent but do not have access to another healthcare facility. Filtering non-emergent patients to retail clinics can thus also improve quality by allowing the hospital to more quickly serve patients who need emergency care.

Despite the potential for cost savings, in certain relationships hospitals and health systems must share the risk of low patient volume with retail clinics, which would make the venture unprofitable. Retail clinics require a low cost of capital per clinic to start up but have high fixed costs, according to Stephan Peron, a principal at VMG Health. Clinics need a certain level of patient volume — Mr. Peron estimates 15-20 patients per day — to break even and offset the fixed costs. Without this minimum volume, the partnered hospital or health system would need to provide ongoing financial support to the retail clinic to maintain its operation. Once retail clinics get patients in the door, however, the patients are likely to return. "Once the patients have been there once and they like the service and the cost is effective, it is highly likely that they will come back," says Mr. Peron. "The hard part is to get the volume up. Once it's up, it's very sustainable."

Retail-healthcare relationships

Although there is the potential for significant benefits from partnerships between retail clinics and healthcare organizations, many challenges remain, including the nature of the relationship between the two entities. "[Participating] health systems will have to enter into a new service model they haven't been in before and rely on the partner to ramp it up and run it," Mr. Peron says. "It's different than a health system partnering with, for example, a surgery center, because the hospital understands how surgeries are conducted and how to operate and work with physician networks to pull in volume. They typically do not have experience in the retail model that is driven directly by the patient versus the referring physician. They will have to rely on their partner, almost fully, to start it, run it and make it financially successful."

However, hospitals' potential lack of control of retail clinic operations is risky. If the retail clinic does not deliver on its promise of maintaining quality, improving patient access and providing cost savings to the patients, it could tarnish the longstanding reputation of the hospital, according to Mr. Peron.

Mr. Peterson says there may be a "melding of views" when retail clinics partner with hospitals. "The retail people are going to bring a retail mindset to the discussion, and the hospital people are going to bring a traditional healthcare provider viewpoint to the discussion. They're going to have to figure out how those two things go together." ■

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Creating an Outcomes-Based Culture: How to Engage Front-Line Staff in Process Improvement

By Imran Andrabi, MD, CEO, Mercy St. Vincent Medical Center

Healthcare reform has drawn a great deal of attention toward bending the cost curve in healthcare, and the Affordable Care Act introduces a number of new programs and initiatives that aim to achieve this. Value-based purchasing, accountable care organizations, bundled payment pilots, medical homes — it's enough to make anyone's head spin. But, when you break it down, all of these are just different ways of going about the same goal — better care that costs less.

An outcomes-based culture

At Mercy St. Vincent, a 445-bed hospital with a Level I trauma center in Toledo, Ohio, we were chasing this idea of better, less expensive care well before conversations around federal healthcare reform really hit. We knew it was coming though — in one form or another — and our goal was to get in front of it. About three years ago, we began to think about how we might redesign our organization to provide better care at a lower cost. To reduce the cost, we knew we needed to improve quality and safety, because doing so takes cost out of the system, and we needed to find a way to make improving these measures a focus for all our employees. Our hospital needed a cultural change.

Given the demands reform places on healthcare organizations, many hospitals and health systems that haven't already gone through this process are embarking on it now. To them, I would advise they give up looking for the silver bullet — something our system had once hoped for — and instead focus on developing a culture that values constant improvement and measurement. Sharing best practices among healthcare organizations is valuable, but it's not the end of the journey. You can't just take a best practice from institution A, move it into institution B and get the results you're looking for. Instead, engage front line workers and utilize them to adapt best practices. Create an environment that gives people permission to try and fail.

Patients first: Journey to zero

Our first challenge at Mercy St. Vincent was figuring out how to define the type of environment we wanted to achieve. Senior leadership sat down and agreed on a system aim, which we often refer to as our north star: "Patients First: Journey to Zero." The first part, Patients First, seems simplistic, but over the last several decades layers and layers of processes have been put into place that take our employees away from direct patient care. "Patients First" is about refocusing every

employee on the patient's outcomes and experience. The second part, Journey to Zero, is about pulling all error out of the organization — zero preventable errors, zero work that needs to be redone. We use the word "journey" deliberately; getting to zero doesn't happen with the flip of a switch. It happens over a period of time.

To do this, we of course needed to improve our processes, but more importantly we had to truly engage the entire organization and put in place a new mindset. We began by educating employees about why a culture focused on outcomes and performance measurement was needed. Each employee was educated on how his or her role would change and front line managers received training on working with and understanding data.

After gaining buy-in for our new culture, we moved on to improving processes. We started with the macro-level goal of reducing our length of stay then moved to examining the micro-level processes impacting the larger issue. For us, that meant essentially examining every process occurring during a patient's hospital stay — from admission to discharge.

A group comprised of senior leadership, front line management, industrial and logistical engineering and Lean Six Sigma consultants began by mapping out the entire timeline for a patient stay from the time the patient shows up at the ER or his or her physician requests an admission until the patient is discharged and the room is cleaned. The group broke down a stay into eight milestones, including 1) initial request for admission 2) bed assignment 3) initial physician order entry for patient, etc. Then, the team broke down every process between each milestone and brainstormed ways to make them more efficient. At this point, front-line employees were engaged and asked to offer additional ideas and critique. Tapping into these employees is critical because they are the ones that understand the processes completely.

Next, we put the new processes to the test, and we saw some major improvements. For example, the time between an initial request for admission and assigning a bed used to take about four hours and require up to eight phone calls. Now, the process takes 10 minutes and zero phone calls. We were able to achieve this by introducing a new technological platform and adjusting human processes around it. We've also had success around speeding up initial physician order entry. We've improved patient transport and nurse processes



in a way that now enable us to require physicians to enter their initial orders for a patient within one hour of the patient getting to his or her bed. At other hospitals, this can take several hours or more. Each of these building blocks has helped us reach our macro goal of reducing length of stay; from 5.2 days to 4 days, and if you factor out our NICU, the average LOS is 3.5 days.

Continual improvement

Even though we've achieved our goals, we don't rest on our laurels; our new culture wouldn't have it — we're all about continual improvement now. Each week a small team of hospital leaders rounds on each unit in the hospital to look at performance against process and outcomes benchmarks and address any variation. They ask questions such as, "What are the barriers keeping us from not hitting the target?" and "What can we do as a team to move the needle?"

The initiative has been so successful that Mercy, our parent organization, is deploying our process across its seven hospitals, and Catholic Health Partners, Mercy's parent organization, is implementing the platform in its other regions

While we didn't develop the initiative in response to healthcare reform, we believe it positions us well to meet reform's demands. Our organization is now keenly focused on high quality care without error, and that very closely mirrors the aim of reform. Additionally, our culture is nimble and the processes we have put in place for continual improvement are robust. The number of core measures we must meet will almost certainly expand, and how our society defines value could change as well. We at Mercy feel confident we'll meet the future demands government and payors place on us because of our culture and the employees within it. ■

Imran Andrabi, MD, currently serves as president and CEO of Mercy St. Vincent Medical Center in Toledo, Ohio. He is a diplomat of the American Board of Family Medicine and the American Board of Managed Care Medicine.

56 Women Hospital and Healthcare Leaders to Know

By Molly Gamble and Jaimie Oh

Here is a list of 56 women who demonstrate outstanding leadership within the hospital and healthcare industry. These women were chosen based on a wide range of critical management and leadership skills, including oversight of hospital or health system operations, financial turnarounds and quality improvement initiatives.

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

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

Noel Brown Williams. Senior Vice President and CIO, HCA Information Technology and Services (Nashville, Tenn.).

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

Diane Corrigan. CFO, Hospital of the University of Pennsylvania (Philadelphia).

Susan Croushore. President and CEO, The Christ Hospital (Cincinnati).

Jacque Daniels. Executive Vice President and Chief Administrative Officer, Novant Health (Winston-Salem, N.C.).

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

Linda Efferen, MD. Senior vice president and CMO, South Nassau Communities Hospital (Oceanside, N.Y.).

Melinda Estes, MD. CEO, Saint Luke's Health System (Kansas City, Mo.).

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

Suzanne H. Freeman. President, Carolinas Medical Center (Charlotte, N.C.).

Mary Freyer. COO, Little Company of Mary Hospital (Evergreen Park, Ill.).

Patricia Gabow, MD. CEO, Denver Health.

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

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

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

Diana Hendel. President and CEO, Long Beach Memorial Medical Center, Miller Children's Hospital Long Beach and Community Hospital Long Beach (Long Beach, Calif.).

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

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

Karen Ignagni. President and CEO, America's Health Insurance Plans (Washington, D.C.).

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

Jan Jones. Senior Vice President and Chief Administrative Officer, Providence Health & Services (Renton, Wash.).

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

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

Jane Keller. CEO, Indiana Orthopaedic Hospital (Indianapolis).

Christy Kindler. Director of clinical information, University Community Health (Tampa, Fla.).

Margaret Lewis. President, HCA Capital Division (Richmond, Va.).

Mary Jo Lewis. CEO, HighPoint Health System (Gallatin, Tenn.).

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

Patricia Maryland. President and CEO, St. John Providence Health System (Detroit).

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

Kristen Murtos. President, Skokie (Ill.) Hospital.

Pamela G. McNutt. Senior vice president and chief information officer, Methodist Health System (Dallas).

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

Peggy Nalepaa, MD. President and CEO, Peninsula Regional Health System (Salisbury, Md.).

Judith Persichilli. President and CEO, Catholic Healthcare East (Newtown Square, Pa.).

56 Women Hospital and Healthcare Leaders to Know

Andrea Price. President and CEO, Mercy (Toledo, Ohio).

Deborah Proctor. President and CEO, St. Joseph Health System (Orange, Calif.).

Mary Prybylo. President and CEO, St. Joseph Hospital (Bangor, Maine).

Paula Register. Senior vice president of physician, ambulatory and continuum services, Carondelet Health Network (Tucson).

Tracy Rogers. Vice president of operations, Alexian Brothers Health System (Arlington Heights, Ill.).

Dawn Rudolf. President and CEO, Saint Thomas Hospital (Nashville, Tenn.).

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

Valinda Rutledge. Director of the Patient Care Models Group, CMS' Center for Medicare and Medicaid Innovation.

Nancy Schlichting. President and CEO, Henry Ford Health System (Detroit).

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

Brigitte Shaw. CEO, Pepin Heart Hospital and Dr. Kiran C. Patel Research Institute (Tampa, Fla.).

Deb Staples. COO, Pennsylvania Hospital (Philadelphia).

Pamela J. Stoyanoff. Executive vice president and COO, Methodist Health System (Dallas).

Sandra A. Van Trease. Group president, BJC Healthcare (St. Louis).

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

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

Margaret Van Bree. CEO, St. Luke's Episcopal Hospital (Houston).

Jamie Welch. Chief information officer, Louisiana Rural Hospital Coalition and the Louisiana Rural Health Information Exchange.

Phyllis Wingate-Jones. President, Carolinas Medical Center-NorthEast (Concord, N.C.). ■

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Shattering Glass Ceilings: Women in the Hospital C-Suite

By Molly Gamble

Healthcare reform has sparked a conversation over the changing role of the hospital executive — the new skill sets leaders will need to develop, the challenge of dealing with change at a rapid pace. America's hospitals need bold, diligent leaders to communicate visions more than ever. It will be interesting to watch how women advance in a healthcare environment that is, at the moment, remarkably progressive.

The female hospital executive is still special in American society, largely since women are underrepresented in top executive roles given their numbers in the field of healthcare. They have made strides, as surveys spanning from the 1980s have suggested, but a 2007 study still found only 15 of the nation's Top 100 hospitals (as ranked by Solucient) were led by female CEOs.

Other findings illustrate key issues that remain serious challenges for female executive leadership development. Surveys of members of the American College of Healthcare Executives, spanning from 1990-2006, concluded that women are much more likely to have previous clinical experience than their male counterparts, and this experience is primarily as a registered nurse. This suggests that, compared to men, top leadership opportunities are more restricted for women without nursing or clinical degrees. It also means there are gender-related differences in credentials considered for executive positions.

Some researchers have also referred to healthcare's "sticky floor," a concept that might receive less attention than the widely-known concept of "glass ceilings." A sticky floor means that while women move up the ranks to attain leadership positions, their salaries will not equal men's for the same position even if experience and skill are on par. This phenomenon isn't confined to non-physician leaders. According to data published by the MGMA in 2010, male physician compensation outpaced female compensation in almost every reported specialty.

To help develop a fuller understanding beyond statistics and figures, three female leaders from hospitals around the country spoke on their experience moving up the ranks, how they balance the demands of a family and a hospital, and how they see women growing in the CEO role. Linda Efferen, MD, CMO at South Nassau Communities Hospital in Oceanside, N.Y.; Peggy Naleppa, MBA, PhD, CEO Peninsula Regional Medical Center

in Salisbury, Md.; and Andrea Price, president and CEO of Mercy, based in Toledo, Ohio, have observed different trends or social shortcomings as women in healthcare, but they all agree on one thing when it comes to female CEOs: there can't be any fewer of them in the years to come.

Women in the workplace

The women who contributed to this piece discussed general observations they've developed over the years involving men and women — findings that might apply to professionals in non-healthcare settings as well.

Dr. Efferen has observed a phenomenon she coined the "invisible person syndrome." "This is when you're sitting in a meeting, and the team around the table is mostly comprised of men. If you say something, there are occasions when that observation or suggestion is not reacted to. Then, when a man says essentially the same thing, it's immediately validated," says Dr. Efferen.

After expressing frustration, a male mentor suggested Dr. Efferen speak a few minutes after conversations evolved and people had the chance to contribute their initial thoughts — a tactic she has found helpful. She's also made conscious efforts to distance herself from behavior, like the invisible person syndrome, that could be interpreted as sexist. "There is still a subconscious barrier sometimes," Dr. Efferen says, referring to comments that carry sexist undertones, albeit unintentionally. "Not taking it personally has helped me move past it," she says.

Ms. Price noticed slight resistance to her leadership role early in her career. "As I began to get promoted to higher levels, I was challenged because I was younger than my direct reports and because I was an African American female," she says. When she assumed her role as vice president within [a children's hospital], some men would ask the president why they had to report to Andrea Price. "Some men used to joke that they had [neck]ties as old as me!" she says, noting that she looked young for her age at the time.

Being compared to a necktie wasn't the only challenge, though. As a young professional, Ms. Price faced a pressing dilemma: whether or not to have kids. "Early in my career, I observed women not getting promoted because they were having children. I had to demonstrate that I was committed to my profession and my job. I didn't get married until I was 30, and I didn't

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have my first kid until I was 32. By that time, I was at the VP level — a level where I was in more control of my time,” says Ms. Price.

In some cases, a woman's awareness of gender-related challenges ended up influencing their leadership style. Dr. Efferen says she does not recall being overtly challenged in regards to her gender, which she attributes partly to her proactive approach. “I've tried to avoid being vulnerable to that. I've been as transparent and fair as possible,” she says.

The lack of female mentorship was a common observation among the women. Ms. Price says the shortage of female leaders resulted in men having a leg up early in her career. “I would see other men in the organization mentoring other men, but I didn't see anyone mentoring females,” she says.

Dr. Efferen noted similar observations when it came to mentorship. “The people I considered significant and supportive mentors were predominantly men. It's not that other women didn't help me along the way, but there weren't and there still aren't as many women in leadership positions,” she says.

Ms. Price also mentioned that when organizations contemplated succession planning, women were rarely considered. “Now that has changed. Mercy now gives me the opportunity to have an executive coach if I want one. Also, I see succession planning based on who is the best fit, the best person for the job — it's not so much about gender or race anymore,” she says.

On a similar note, another observation mentioned during discussions was that of women receiving promotions based on hard work and effort, while men were more likely to receive advancements based upon their skill sets. “For example, if somebody were to advance to a leadership role, for a woman it might be because of her strong efforts or because she was a good RN, opposed to meeting broader skills around finance and budget,” says Ms. Naleppa.

Striking a work-life balance

Ms. Price illustrated a day in the life of her juggling act: early mornings in the office, evening board meetings at night. “Then I'll come home and my kids will tell me they have a party at school tomorrow and need cupcakes for it. Or they need help with this science presentation,” she says, noting that they wait for her to return home to ask for help with these tasks. “Despite my title and professional accomplishments, I'm still Mom. I'm still looked to as the primary caregiver in my family,” says Ms. Price.

Women face some unique conditions that influence their careers — crucial decisions that men may not find as pressing, such as whether or not to have

children. Many successful women have achieved work-life balance without a delineated plan, and women contributing to this story said they had not leant much thought to *how* they juggle it all — it just naturally happened.

Ms. Price says the work-life balance goes beyond her own life, which includes a physician husband and four children. It has become a professional responsibility, as she feels the need to create an atmosphere that fosters satisfaction for employees in regards to work-life balance. Fitness initiatives, workout facilities and a caregivers' fund for employees with sick or deceased family members help Mercy employees feel comfortable and secure, according to Ms. Price.

Some women prefer to establish firm boundaries — or as defined as possible — between work and family. “The way I find balance is through a separation and inclusion strategy,” says Dr. Efferen. “By separation, I created fairly hard lines or boundaries. Barring an emergency situation, when I was home, I was home. When I was at work, I was at work. Yet, on the flip side, I also tended to push boundaries a bit.”

Sometimes, Dr. Efferen couldn't silo her responsibilities as a mother and working professional. When evening dinners with a professional organization conflicted with family time and dinner with her kids, she began bringing her children with her after asking for permission. Subsequently, more parents began bringing their children, as well. “Over the years, I think there's been more of an understanding that we need to consider people's responsibilities outside of their job,” she says.

A simple strategy worked best for Ms. Naleppa in achieving work-life balance: saying no. “I had to learn how to step back,” she says. She was holding down a vice president position within a community hospital and raising two daughters when she began a master's program in the late 1980s. “I didn't feel I could balance full-time school, full-time senior position, mom and wife,” says Ms. Naleppa. “So I stepped out of that position for the time. I had to learn for myself how to prioritize and say no.”

Yet, while she has become better at prioritizing, Ms. Naleppa doesn't encourage women to over-organize. “When I think about balance, I don't think about putting things into boxes. I don't ask myself, ‘Well, should I do this two hours a day, or this two hours a day?’” Throughout her career, she says her worlds as CEO, mother, wife and various other roles meshed in a way she now finds fulfilling.

The future for women hospital CEOs

One thing is certainly true: there won't be fewer women CEOs in the future. “When you look at health management programs grad schools, there are more women than men in those programs. With these changes in healthcare, I think women will play a more prominent role in leadership,” says Ms. Price. “I think people want more innovative leaders, and women are going to be an important part of the mix in executive teams.”

Dr. Efferen says there is still a way to go before we achieve 50/50 representation by men and women in senior leadership positions in hospitals, and a less-siloed approach to healthcare would help this greatly. “Up until now, medicine has been put into silos. Nurses go to nursing school, physicians to medical school, and then we're all thrown together and expected to play as a team,” she says. An integrated approach to leadership development might not only help women advance, but the healthcare industry as a whole.

Women just coming out of medical school or healthcare management programs are likely to see more plentiful and richer career opportunities in healthcare as well, particularly in terms of leadership. It will also be interesting to see if the generation that expanded their careers without female mentorship reverses that trend and provides guidance for young women today. “My goddaughter, who is a physician, is very bright and her opportunities today will be much more broad than if she graduated 30 years ago,” says Ms. Naleppa. “It's exciting. We have great national examples of female CEOs.” ■

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False Claims Based on Unneeded Procedures: 4 Strategies for Compliance (continued from page 1)

Additionally, hospitals should be informed and proactive about two specific healthcare trends that have emerged in the past year: unnecessary cardiovascular stenting and physician-owned distributorships. Scott Becker, JD, partner with McGuireWoods in Chicago, comments on these trends and explains how hospitals should be cognizant of unnecessary care in times of increased compliance scrutiny.

The risks hospitals face

According to CMS, no Medicare payment shall be made for expenses incurred for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,” according to the Medicare Program Integrity Manual. To combat Medicare reimbursements for unnecessary procedures, CMS developed National Coverage Determinations. These determinations are made through an evidence-based process, where CMS’ research can be combined with that of outside consultants and the Medicare Evidence Development and Coverage Advisory Committee.

Hospitals face a range of risks when it comes to billing for unnecessary care, even if it occurs without the hospital’s knowledge. Claims for services that are medically unnecessary will be denied, but the lack of reimbursement is a small risk compared to the penalties hospitals may face. If Medicare or other payors determine that services were medically unnecessary after payment has been made, they demand that the money be refunded with interest. If payors discover a pattern of such claims, the physician or provider may face large monetary penalties or settlements, exclusion from

Medicare or Medicaid, and possible criminal prosecution. They could also be at risk for medical malpractice awards to patients who file suits over receiving an unnecessary procedure.

Cardiovascular stents

Tiny mesh tubes that prop open blocked arteries have been the root of large legal problems for some hospitals. Stent implant procedures, which cost approximately \$20,000 each, have attracted a fair amount of scrutiny due to some physicians’ abuse of the service.

In July, a cardiologist from Salisbury, Md., was convicted of healthcare fraud and other criminal charges after he placed unnecessary coronary stents in more than 100 patients. John R. McLean, MD, then falsely recorded in the patients’ medical records the existence or extent of coronary artery blockage to justify the stent and the submission of claims to healthcare benefit programs. He billed hundreds of thousands of dollars to Medicare, Medicaid and private payors for the implants, and now faces a minimum of 35 years in prison.

“The evidence shows that Dr. McLean egregiously violated the trust of his patients and made false entries in their medical records to justify implanting unneeded cardiac stents and billing for the surgery and follow-up care,” U.S. Attorney Rod J. Rosenstein said in a press release. “We do not bring federal prosecutions based on discretionary judgments that might be disputed by reasonable medical professionals.”

Legal repercussions are not limited to physicians who implant the unnecessary stents, however. Hospitals can find themselves in the crossfire, facing federal charges, class-action lawsuits from patients and regulatory penalties from the Office of Inspector General or other departments.

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Dr. McLean had privileges at Peninsula Regional Medical Center in Salisbury. In August, the hospital agreed to pay \$1.8 million to settle federal allegations that it failed to prevent Dr. McLean from implanting the stents. It also agreed to repay federal funds it may have received for stents Dr. McLean used. Following the settlement, PRMC agreed to have its cardiac catheterizations overseen by an independent review organization as part of a corporate integrity agreement with the Office of Inspector General and Department of Health and Human Services.

Unrelated to Peninsula Medical Center, two physicians within Greensburg, Pa.-based Excelsa Health system implanted alleged unnecessary stents in patients from 2009-2010. After notifying 141 patients that their stent may or may not have been necessary, the system saw an initial wave of 34 patient lawsuits in July with more expected to follow. One class-action suit charges Westmoreland Hospital, an Excelsa site where some of the unnecessary procedures occurred, with failure to get informed consent to perform surgeries, enrichment from performing surgeries without obtaining informed consent and administrative negligence.

Physician-owned distributorships

Physician-owned distributors only emerged in the past 10 years but have managed to spark plenty of debate. In a POD, a physician owns part of a firm that sells devices or implants to hospitals or ambulatory surgery centers where the physician works. The physician then keeps the profits from those sales.

In June, the Senate Finance Committee minority staff launched an inquiry into PODs and published a report highlighting their concerns — one being that PODs may result in procedures being driven by financial incentives rather than patient need. “This is especially troubling given numerous concerned allegations provided to the Committee that, due to their financial interest, physician investors in PODs may perform more procedures than are medically necessary,” the bipartisan report read.

A *Wall Street Journal* news report later illustrated the Senate committee’s concerns. In the spring, Providence Portland (Ore.) Medical Center revoked a neurosurgeon’s privileges after learning that his rate of multiple spinal-fusion surgeries was nearly 10 times the national average. Vishal James Makker, MD, operated on the spines of some patients up to seven times. The *Wall Street Journal* reported a later development in the case, revealing Dr. Makker was involved in a physician-owned distributorship with Omega Solutions, a spinal implant distributor.

PODs show that the need for physicians’ disclosure of financial arrangements has moved beyond relationships with vendors or accepting gifts from device makers or pharmaceutical companies. Hospitals should be mindful of the disclosure and documentation of these types of relationships between physicians and device companies. Armed with this knowledge, hospitals can take the necessary steps to ensure POD-involved physicians are not driving surgeries for financial gain in their facility.

Legal strategies for hospitals

No hospital wants to play a part in news stories like those mentioned, but providers shouldn’t assume immunity to such incidents. Mr. Becker says four core strategies can help guard against billing for unnecessary procedures.

1. Coding audits. The billing/coding audit is the first line of defense, and hospitals should perform this on an annual basis — at least. “Hospitals should look at medical records and essentially assess if there’s proper documentation, meaning proper medical or legal information that backs it up,” says Mr. Becker. A wide variety of third-party consultants and firms can offer developed expertise in these areas to help ensure that hospitals are properly billing and coding procedures performed. These audits can be performed either internally or externally.

Certain trends are more likely to trigger governmental audits, such as a high concentration of procedures in areas that generate larger percentages of hospital collections, or when a hospital capitalizes on certain aspects of the Medicare program. Hospitals should focus on these areas to maintain compliance. Proper documentation is crucial to supporting medical necessity for services. By charting medical decision-making and physicians’ thought processes, providers can support medical necessity through objective and clear documents.

Still, audits are not a surefire way to prevent problems since charting or coding is not always an accurate indication of necessity. “There is a downside to billing and coding audits: they don’t address the issue of physicians who have become skilled at deception. If physicians chart a certain way, they can document for a condition that’s not absolutely present,” says Mr. Becker.

2. Remaining alert to complaints. Hospitals should be vigilant and open to any complaints or signals of potentially inappropriate conduct by physicians. “One of the worst cases for medical necessity was when a pain management physician was performing procedures and nurses complained. They told the hospital the procedures might have been unnecessary and [may have been] performed to rack up dollars. The hospital waited too long [to investigate],” says Mr. Becker.

Certain specialties are more subjective and may require additional discretion. “A broken leg is a clear diagnosis, but other conditions are not that objective,” says Mr. Becker. If a hospital does receive a complaint from an employee over a physician’s adherence to necessity, it should immediately pursue an internal or external review to assess the argument.

3. Maintain regular reviews of physicians’ numbers. In addition to physician charting and medical documentation, medical necessity is often examined by comparing diagnosis codes with procedure codes. “Keep an eye on which physicians’ numbers are going way up or way down,” says Mr. Becker, as dramatic shifts could indicate a problem. “If somebody has a spike in numbers, it’s worth trying to figure out why. Are they moving more business to your hospital, or should you be concerned they’re hiking that up by performing unnecessary procedures?”

4. Enforce policies where physicians have to disclose relationships with vendors. Whether it’s a POD or another relationship with a vendor, pharmaceutical company or device-maker, hospitals should enforce policies that mandate the disclosure and documentation of such arrangements. “Physicians have developed consulting relationships of all sorts. You want to ensure these relationships are reported. That way, if the physician starts using a specific type of stent, you know there may be separate motivation,” says Mr. Becker. ■

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Non-Profit Hospitals Taking More Aggressive Stance Toward M&A, But Deals Aren't Always Easy (continued from page 1)

(Ky.) University Hospital, and non-profit Provena Health in Mokena, Ill., recently signed a deal to merge with Chicago-based Resurrection Health Care. Novi, Mich.-based Trinity Health has also been active in merging hospitals in western Michigan, and Duke University Health System in Durham, N.C., partnered with LifePoint Hospitals, a for-profit hospital manager based in Nashville, Tenn., to buy and run community hospitals in North Carolina.

So why the influx? And are non-profit hospitals expected to stay active amidst dwindling funds? The Patient Protection and Affordable Care Act has certainly been a driver of the recent trend as health systems look to work collaboratively to offer quality patient care, but a non-profit hospital's access to capital — and scarcity of capital — are also propelling the robust M&A market forward.

Impact of healthcare reform

When PPACA was signed into law on March 23, 2010, the government looked at the healthcare system and how it could reduce overall costs and improve quality care for patients. The solvency of the Medicare and Medicaid systems coupled with the PPACA have led to one certainty that is already taking place: Reimbursements, both private and public, are decreasing for providers, and providers must now find ways to offset those reductions while entering into a 21st century healthcare system surrounded by technological upgrades and preventive patient care.

So for non-profit hospitals — which include academic medical centers, religious systems, community hospitals and hospital districts — this means finding ways to help bear new costs and cuts with limited capital, and many are looking to affiliate with other systems and physicians' practices. Steven Bjelich, president and CEO of non-profit Saint Francis Medical Center in Cape Girardeau, Mo., says the healthcare reform impacts all parties in all regions, and it has led his hospital to employ 117 physicians in various specialties to both help the physicians as well as his hospital. "Bringing physicians and their practices on board helps to stabilize our referral base and to ensure patients have access to quality care regardless of their payor source," he says. "Under the incentives created by healthcare reform, it is imperative to become a physician-led and physician-driven organization."

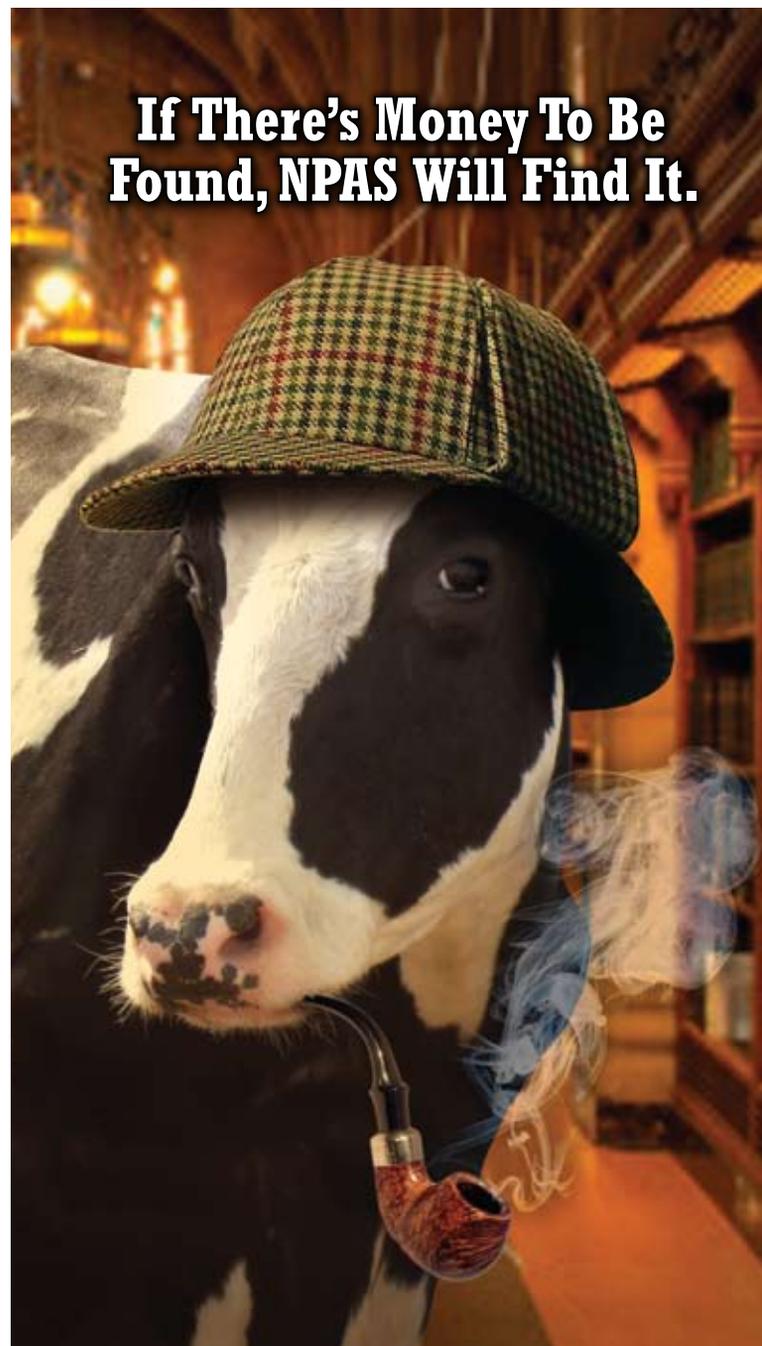
The acquirers and the acquired

If a non-profit hospital is acquiring another hospital, like CHI's proposal, that hospital is most likely a "strong player," says Bart Walker, JD, partner at McGuireWoods. While the biggest non-profit systems and the mid-size systems have the capital to pursue the purchase of another hospital, small non-profits simply don't have that ability. Instead, they are looking at affiliating with physician's practices.

Nolan Newman, CPA, founder of Newman Dierst Hales, a Seattle-based accounting firm that serves healthcare providers, adds that hospitals that do the acquiring depends on the size of the hospital, the hospital's borrowing capacity and the overall scarcity of capital in the market.

Physician groups, overall, are the largest source of growth in the healthcare M&A market. Physician practice merger activity has increased 200 percent from the second quarter of 2010 to the second quarter of 2011, according to a report from Irving Levin Associates, and that's where non-profit hospitals can stay in the game to meet the demands of healthcare reform while expanding their business opportunities. "Small hospitals don't have the wherewithal to buy another hospital," Mr. Walker says. "But they have been more active and more open to joint ventures with physicians and acquiring ancillary services. In the end, I think all of the hospitals are looking for ways to grow."

That is exactly the field where Mr. Bjelich has expanded Saint Francis. The Medical Group Management Association found 65 percent of established



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physicians and 49 percent of physicians hired out of residencies or fellowships were placed in hospital-owned practices in 2009 due to higher starting compensation. "Physicians coming out of residencies are seeking employment with hospitals to assist in relieving the huge expense of medical school," Mr. Bjelich says.

Benefits and other considerations

Mr. Walker says there is one clear motive why non-profit hospitals are staying active in the M&A market: payor reimbursement contracts. "One of the big reasons [to merge and acquire] is to have greater negotiating power with payors," Mr. Walker says. "The smaller providers are being squeezed by payors, and it's tougher to get better rates."

Milton Cerny, JD, counsel at McGuireWoods, also adds, "A lot of reimbursement rates have gone down for physicians and private practices, and they are looking to hospitals to get more leverage to negotiate payor contracts."

Purchasing electronic health record systems has also been both a goal and benefit for some non-profits merging. For example, a 200-bed community hospital and a 2,000-bed hospital system may need to buy and implement EHRs. "The 2,000-bed system is going to have a financial advantage because it can spread the cost and overhead over more units," Mr. Newman says. "And it probably has better borrowing capacity than a smaller hospital." For some smaller hospitals, affiliations and mergers may be the answer to control those types of large, EHR-based capital projects.

The same applies to physician's practices. An individual physician within a practice can spend up to \$10,000 on EHRs initially, and there are also the annual hardware and software maintenance costs, Mr. Bjelich says. Physician practices that are unable to front all EHR costs, like some small hospitals, also turn to bigger health systems to make the transition easier. "Because of the resource of extra staff, hospitals and health systems have an advantage over private physician offices to make that conversion with less downtime," Mr. Bjelich says.

Rural non-profit hospitals are in a particular bind, though. Mr. Newman says they may not have the size or scale to support massive capital projects such as EHRs on their own. Additionally, there may not be as many interested systems that want to merge with those rural hospitals due to their remote location and sparse patient base. While there have been some rural affiliation transactions, they are not as prevalent.

Payor reimbursement and technology upgrades are some of the benefits of acquiring another hospital or practice, but non-profit hospitals still must keep certain items in mind. As non-profit hospitals undergo these transactions, Mr. Cerny says the number one goal is to protect the tax-exempt status, but hospitals must also be mindful of the unrelated business income (i.e., Is a hospital regularly generating income that is not related to its exempt purpose or mission?), be able to submit clear reports to the Internal Revenue Service and be able to conduct community benefit analyses to show their value within the community.

"Attorneys structuring these transactions have to be careful advising hospital systems," Mr. Cerny says. "Always apply fair market value of standards and a rigorous due diligence policy. Closely examine these transactions to make sure there are no potential hidden costs. It is important that senior management understands that the acquisition of a new physician practice will affect the management structure of the hospital organization."

Religious institutions must also be mindful of several factors. For example, the potential merger between CHI's Catholic-based hospitals and Louisville's University Hospital has drawn a lot of criticism and governmental scrutiny because it has not been made clear if the taxpayer-supported University Hospital would adopt Catholic ideals on reproductive care, end-of-life patient care, tubal ligations and other issues. Mergers between religious systems and publicly funded systems walk a fine line between the separation of church and state. If matters such as those in the CHI-University Hospital case are not covered upfront, deals could hit a huge snag or not be approved at all.

Non-profit hospitals, M&A and the future

Hospital acquisitions of physician practices, however, do not seem to be dying down anytime soon. "In my opinion, the number of non-profit hospitals acquiring practices will continue to grow," Mr. Bjelich says. "I see the need for hospitals to transition away from the constraints of the traditional voluntary medical staff toward committed physicians who will partner with them and join their priorities around more standardized measures of quality performance, patient safety, efficiency and patient satisfaction."

Mr. Walker agrees that the current healthcare reform and flailing economic climate will lead to more non-profit hospitals merging, be it with another hospital or several physicians' clinics. "I think the trend is toward greater consolidation," he says. "Capital is relatively cheap right now, and they can issue bonds at a relatively attractive rate."

Whatever non-profit hospitals do, though, the executive team must know all ramifications before they finalize a merger, affiliation or partnership. Payor reimbursement contracts, refinancing of new debt and increased management of more moving parts will all surface. "From a leadership standpoint, have a management team that is very clear about its strategy to affiliate or remain independent, and there also needs to be clarity of strategy at the board level," Mr. Newman says. ■

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When Physician Employment Doesn't Make Sense: How to Turn Away Physicians Seeking Employment

By Sabrina Rodak

Physician employment at hospitals is steadily growing, and is expected to reach unprecedented levels in the coming years. A study by Accenture, for example, estimates that only 33 percent of physicians will be independent by 2013. Many hospitals are employing physicians to improve coordination of care, which is a major focus of healthcare reform legislation. Alignment with primary care physicians will be particularly important for hospitals interested in forming accountable care organizations because they will be patients' central point of contact in the ACO. In addition, many hospitals may want to employ primary care physicians to prepare for the predicted shortage of these physicians. In turn, many physicians, particularly recent medical school graduates, are seeking employment at hospitals to achieve a better work-life balance and/or to avoid the administrative burden of running an independent practice.

While there are many potential benefits of physician employment by hospitals for both parties, there are also downsides and risks that may cause hospitals to limit or exclude physician employment as part of their strategic plan. In these cases, hospitals may need to turn away physicians and must do so in a manner that minimizes conflict.

Physician employment considerations

One of hospitals' first considerations when deciding whether to hire physicians should be the hospitals' ability to manage employed physicians or physician practices, according to Allen Kram, director of physician development for LaGrangeville, N.Y.-based Health Quest.

Jennifer Metivier, MS, FASPR, executive director of the Association of Staff Physician Recruiters, agrees. "[Hospitals] may not know how to do billing for physicians or be set up to run a practice efficiently," she says. Employing physicians requires a significant investment of time, money and effort — resources that a hospital may not be able to afford, particularly as Medicare cuts threaten their continuing viability. "Certain specialties' malpractice insurance is extremely expensive and it may deter a hospital from employing a physician in that particular specialty," Ms. Metivier says. A study in the *New England Journal of Medicine*, for example, found that 19 percent of neurosurgeons face malpractice suits each year.

In addition to financial costs, physician employment may call for hospital executives to learn new leadership skills, especially if the employed physicians are coming from a private practice, which affords them more autonomy. To succeed with employed physicians, hospital leaders will need to truly integrate them into the hospital's structure and operations. "Signing the employment agreement is not the end of the physician engagement process," says Bryan J. Warren, manager of Select International's Healthcare Solutions division. "Now the physicians' success [or failure] is really your success or failure," he says.

Hospital leaders should also consider their competition when deciding whether to employ physicians. "If you do not hire/employ the physicians, what will your competition do?" Mr. Kram says. "In many cases, the decision to hire physicians is to make the relationship with the community physicians stronger and in other cases it is a strategic move to either increase market share or grow a service line that is not being met in the community," he says. Thus, hospitals may want to employ physicians as a defense against competition. However, this move may be seen by physician practices in the community as an aggressive or offensive move. "If there are strong prac-

tices in the community that are providing the services, you might not want to compete or risk losing the support of those practices," Mr. Kram says. Furthermore, if physicians in the community are already referring patients to the hospital, employing these physicians would incur costs without adding much benefit in terms of volume.

If hospitals decide to hire physicians, the next step is to develop a process for choosing which physicians to employ. A critical consideration in this case is the physician's alignment with hospital culture. Hospitals should not hire physicians who do not fit the organization's culture, even if they are otherwise appealing, because they can cause conflict with other physicians and employees in the hospital and impede efforts to reach the organization's short- and long-term goals. "You can't just hire the [physician] who gets many cases; you need physicians who are adaptable, can handle change and are going to be collaborative," Mr. Warren says.

He suggests hospitals first define their culture and its components and then create an interview process that targets these areas. Defining one's culture may be a challenge, however, particularly when defining the culture from the physicians' perspective, says Manoj Pawar, MD, vice president of clinical operations and physician leadership development for Englewood, Colo.-based Catholic Health Initiatives. He suggests involving the hospital's current physicians in the definition process. One technique he uses is asking physicians the three physicians they would want on their "dream team" and why. "This can very quickly and easily be translated into elements of our culture," he says.

Turning physicians away? How to minimize problems

1. Articulate your stance. One of the keys to turning down physicians seeking employment is articulating the hospital's stance towards physician employment. "Have a concrete plan [for physician employment] ahead of time," Dr. Pawar says. For example, he says hospitals should define how many physicians they want to employ, if any, what specialties they are targeting, their timeline for recruitment and perhaps most importantly, the reasons for wanting or not wanting to employ physicians. "Make sure you have an actual business plan and strategic reason for wanting to do this," he says. Establishing a business plan for physician employment will help guide hospital leaders in how to respond to physicians seeking employment.

2. Establish a recruiting process. If physician employment is part of a hospital's strategy, the leaders need to develop a deliberate process for recruitment and communicate this process to members of the team and to the physicians seeking employment. "Inconsistency in the negotiations and courting of a physician or group is the biggest mistake made by hospital leadership," Mr. Kram says. "There should be a clear understanding of the process the administration goes through in deciding to make an offer." By creating a specific plan with clear expectations, hospital leaders can more easily explain and physicians can more readily understand why they were not hired.

3. Involve current physicians. Turning down physicians may be most effective and constructive if physicians are leading the recruitment efforts. "The best possible scenario is to create a medical group with its own governance where the physicians themselves are making [the hiring] decisions," Dr. Pawar says. Peer-to-peer communication may make the phy-

sicians seeking employment more understanding of a decision not to hire them because there is not a power imbalance, as there would be with an administrator rejecting a physician applicant. “To be really successful, hospitals need to get out of the mindset of hospitals employing physicians,” Dr. Pawar says. “Create a group or structure that [is] physician-led.” Developing a governance structure for physicians will make them more engaged in the hospital and invested in the physician employment strategy.

4. Explore other options. If physician employment is not part of a hospital’s strategy, one way to turn away physicians who are seeking employment is to explain that hiring physicians is not currently part of the hospital’s business plan. However, this response may limit leaders’ options, Dr. Pawar says. Instead, he suggests leaders think creatively about other ways the hospital can work with the physicians. “It’s not either/or,” Mr. Warren says. “Within a given service line, you don’t have to decide whether

to employ everybody or not; it may make sense to employ some and continue to work with [others as] independent staff,” he says. Other arrangements between hospitals and physicians include co-management, contracting for certain services and leasing office space.

Hospital leaders should talk to physicians about their motivation for employment to identify ways the hospital can form relationships with physicians without employing them. “It’s important to not stop at the initial request [but to] dig deeper,” Dr. Pawar says. This type of conversation might reveal that the physician has on-call coverage issues, economic challenges or other problems the hospital can address without hiring them. Mr. Warren suggests operational alignment as a first step in forming a non-employment relationship with physicians who may be burdened by their practices’ administrative demands. ■

Study: Push for Market Share Trumps Clinical Integration in Hospitals’ Rush for Physician Employment

By Jaimie Oh

While not new, the pace of hospital employment of physicians has quickened in many communities, driven largely by hospitals’ quest to increase market share and revenue, according to a study released today by the Center for Studying Health System Change.

Hospitals’ primary motivation for employing physicians has been to gain market share, typically through service-line strategies encouraged by a fee-for-service payment system that rewards volume, according to the study. Meanwhile, physicians’ interest in hospital employment has grown in response to stagnant reimbursement rates, rising costs of private practice and a desire for a better work-life balance.

While greater physician alignment with hospitals may improve quality through better clinical integration and care coordination, hospital employment of physicians does not guarantee clinical integration, according to the study.

The trend of hospital-employed physicians also may increase costs through higher hospital and

physician commercial insurance payment rates and hospital pressure on employed physicians to order more expensive care. Other key findings from the HSC survey include the following points:

- Hospital employment of physicians is growing rapidly across 12 nationally representative metropolitan communities. Exceptions are Orange County, where California law bars hospitals from directly employing physicians, but physicians tend to be tied closely to hospitals through other means; Boston, where physician organizations keep non-employed physicians tightly aligned with the dominant hospital system; and northern New Jersey.
- Hospital consolidation continues to be an important factor in physician employment by hospitals. In markets with high hospital concentration, physicians face pressure to align closely with one hospital system or another.
- While hospital employment of physicians is more pronounced in areas with higher levels of hospital consolidation, it is also taking place in less-consolidated hospital markets. ■

Survey: Most Medical Practices Operating at a Loss

By Lindsey Dunn

A recent study by the American Medical Group Association found most medical groups across the country are operating at a loss.

According to findings in AGMA’s 2011 Medical Group Compensation and Financial Survey, the only region where medical groups neared break even (-\$27 per physician) was in the Western region.

The Northern region suffered a \$10,669 loss per physician on average. Practices in the Southern region lost \$1,870 on average, and practices in the Eastern region averaged a loss of \$1,597 per physician.

According to Donald W. Fisher, PhD, CAE, president of the AGMA, many of these practices are able to remain viable by supplementing practice losses with non-clinical revenue sources or funding from associated health systems. ■

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6 Ways Hospitals Can Survive the Onslaught of Medicare Cuts

By Sabrina Rodak

Although healthcare leaders are concerned about major cuts in Medicare funding, many may not grasp the true scope and impact of these reductions on hospital operations and the delivery of care. Ken Perez, director of MedeAnalytics' healthcare policy team and the senior vice president of marketing, says hospitals need to understand the magnitude of potential losses so they can take measures to offset reduced revenue.

The numbers game

MedeAnalytics estimates that on average, hospitals will face a total reduction in Medicare Inpatient Prospective Payment System reimbursements of \$5 million per year for ten years.

MedeAnalytics calculated this estimated \$5 million reduction in hospital payments by considering the following:

- The Patient Protection and Affordable Care Act plans to cut IPPS funding through decreases to the annual market basket updates (via reductions and productivity adjustments) by \$112.6 billion from FY2010-FY2019.
- Additionally, the federal government aims to reduce expenses by \$1.2- \$1.5 trillion over ten years through a committee created by the Budget Control Act of 2011.
- As Medicare accounts for approximately 13 percent of the federal government's budget, the reduction to Medicare to meet the \$1.2- \$1.5 trillion goal would be approximately \$150- \$200 billion.
- The IPPS is 32.7 percent of Medicare's budget; therefore, one would expect \$50- \$65 billion of the Medicare reductions would be cut from the IPPS.
- Dividing the \$50-\$65 billion by the roughly 3,400 hospitals that participate in the IPPS indicates that the average hospital would lose \$1.5-\$1.9 million in IPPS funds per year for the next 10 years, or approximately 2.3-2.9 percent of its funds.
- The \$112.6 billion in cuts per the PPACA in addition to the estimated \$50-\$65 billion in possible cuts from the debt deal yields a total approximate reduction to IPPS reimbursements of \$162-\$177 billion, or an average of \$5 million per hospital per year for 10 years.

These calculations do not take into account potential cuts to Medicare programs outside of the IPPS, including graduate medical education and Medicare's coverage of 70 percent of hospitals' Medicare bad debts, which would create additional losses for hospitals.

Improving care delivery

To manage the projected reductions in Medicare funding, hospitals will need to improve the way they deliver care instead of trying to achieve gains from cutting administrative costs alone. "Fifteen percent of the total income statement is administrative. You can't get much more efficiency out of the administrative bucket. The most promising area to offset reductions in Medicare reimbursement is the process and delivery of care — the core activity of the hospital," Mr. Perez says. He says this strategy benefits not only the hospital's finances, but also its efficiency.

The hospital's CFO is best positioned to champion this initiative because of his or her familiarity with the hospital's finances, according to Mr. Perez. In addition, Mr. Perez says successful strategies should be able to take effect within six months because "hospitals don't have five years or 10 years to sustain losses. There is a sense of urgency."

MedeAnalytics recommends the following six strategies CFOs can use to combat Medicare losses quickly.

1. Partner with clinical leadership. CFOs should reach out to clinical leadership, such as the CMO, to solicit their support. "Explain the situation we're in and explain the dynamics associated with the financial model for the hospital. Many clinical leaders lack that financial information," Mr. Perez says. MedeAnalytics' white paper "Medicare Zero: A Comprehensive Analysis of the Impact of Health Reform and the Debt Deal on Medicare Funding of Hospitals and Strategies of Financial Survival," identifies CFOs' three goals for the first meeting with clinical leadership:

1. Provide an assessment of the current financial condition of the hospital.
2. Explain the impending increased financial pressures and their likely impact on the organization.
3. Solicit the support and assistance of the clinical leadership team.

2. Conduct a detailed margin analysis. The CFO needs to understand where the hospital is making and losing money to make any meaningful changes. "Without the data, [a financial plan] is just a bumper sticker, a slogan," Mr. Perez says. Specifically, the CFO should analyze profit margins of MS-DRGs and service lines at the physician and patient level to target areas for improvement.

The MedeAnalytics white paper suggests that the hospital finance department focus cost-saving strategies on the MS-DRGs that have a higher cost than actual reimbursement. CFOs should also look closely at the five MS-DRGs/service lines with the highest volumes, highest profitability and greatest losses, respectively, to determine the causes of the profit or loss. Furthermore, the finance department should perform margin analyses on an ongoing basis with service line managers, physicians and the senior management team to develop strategies to capitalize on the high-performing areas and improve low-performing areas.

3. Engage with service line managers and physicians. MedeAnalytics' white paper also recommends CFOs create a clinical performance improvement action team comprised of service line managers and physicians to address metrics such as supply utilization, length of stay, drug costs, readmissions within 30 days of discharge, and ancillary testing usage.

Mr. Perez says CFOs should provide the service line managers and physicians with scorecards that include these metrics so they can compare their performance to the hospital's objectives, their peers and national benchmarks. "You need to have data to be part of the solution and not part of the problem," he says. He suggests hospitals identify high-performing physicians and use them as role models for best practices.



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The CFO, in partnership with the service line managers and physicians, should also review Medicare and Medicaid clinical denials and work to prevent future denials, according to Mr. Perez. Strategies to avoid claim denials include creating a clinical documentation improvement program for special care areas and surgical floors and emphasizing accurate and complete coding to physicians.

Improving clinical documentation for coding purposes will be particularly important as hospitals move from the ICD-9 to ICD-10 code set, as ICD-10 includes significantly more codes and requires more detail. Correct documentation is important not only for assigning the appropriate codes, but also for justifying medical necessity. In fact, the American Hospital Association's May 2011 RACTrac survey found that 84 percent of participating hospitals with complex denials cited medical necessity as a reason for denial. Medicare recovery audit contractors have collected more than \$575 million in overpayments since Oct. 2009. Investing in documentation training could yield significant returns in savings from avoiding claim denials and appeals.

Another way the CFO, service line managers and physicians can benefit from a partnership is by establishing financial-clinical grand rounds to review cases of costs, care and outcomes that can be used to create standards of care.

4. Revamp care coordination. Ensuring successful care coordination is essential to saving costs. "It's critical because if it's not coordinated, then handoffs are poor and there are duplicative tests and delays, which add to the length of stay and cost," Mr. Perez says. By improving care coordination policies, such as the discharge process, hospitals can avoid readmissions, which will be penalized by CMS.

There are multiple models designed to improve care coordination, including accountable care organizations, patient-centered medical homes and private payor-provider relationships. While hospitals may want to consider these long-term projects to significantly change the coordination of care, there are also short-term options that can produce savings and improve patient safety.

For example, the MedeAnalytics white paper suggests using checklists and auditing to verify medication information, follow-up appointments, the primary caregiver at home, diet and exercise parameters, need for home healthcare visits and notifications for calling the physician. In addition, discharge summaries should be sent to primary care physicians so the transition from the hospital to home is error-free.

Mr. Perez suggests hospitals join a health information exchange to better coordinate patient care, as HIEs allow providers within a region to communicate effectively. Other health IT projects, while not as easy to implement as checklists, can also help hospitals improve care coordination and save money. CMS offers incentives for meaningful use of electronic health records, for instance.

5. Optimize operating room efficiency. "ORs are major sources of revenue, but also of cost, labor and consumption of supplies," Mr. Perez says. CFOs can increase OR efficiency by improving scheduling, standardizing processes and considering process improvement events, all of which can reduce delays and their associated costs. Other metrics to track and improve include start time, operating time, turnover time and post-anesthesia care unit admission delays. Hospitals should use data analytics to identify top performers who can share best practices with colleagues, according to the MedeAnalytics white paper.

6. Improve emergency department operations. "This is an entry point that is very abused in terms of appropriate versus inappropriate usage," Mr. Perez says. Hospitals should perform data analyses to review ED supply

and drug utilization, ancillary testing and inappropriate usage. Mr. Perez suggests hospitals consider what alternatives, such as urgent care or retail clinics, might be more appropriate for certain patients and less costly for the hospital.

In some markets retail clinics have gained ground because they increase patient access to non-emergent care, decreasing inappropriate ED use. Diverting crowds from the hospital ED can save the hospital money by allowing physicians to spend emergency resources on the patients who need them most. Urgent care clinics also preserve ED use for patients with emergency needs but provide care beyond the typical hours of retail clinics or primary care physicians. ■

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CMS Issues

Final IPPS Rule, Net Medicare Reimbursements to Increase 1.1%

By Bob Herman

The Centers for Medicare & Medicaid Services issued its final IPPS rules that will implement a 1.1 percent net increase, compared with FY 2011, in total Medicare operating payments to acute-care hospitals.

In the proposed rule, there would have been a 0.55 percent cut to hospitals' FY 2012 reimbursements, but the final rule will increase payments to hospitals overall by an estimated \$1.13 billion. The IPPS for FY 2012 will go into effect Oct. 1, 2011.

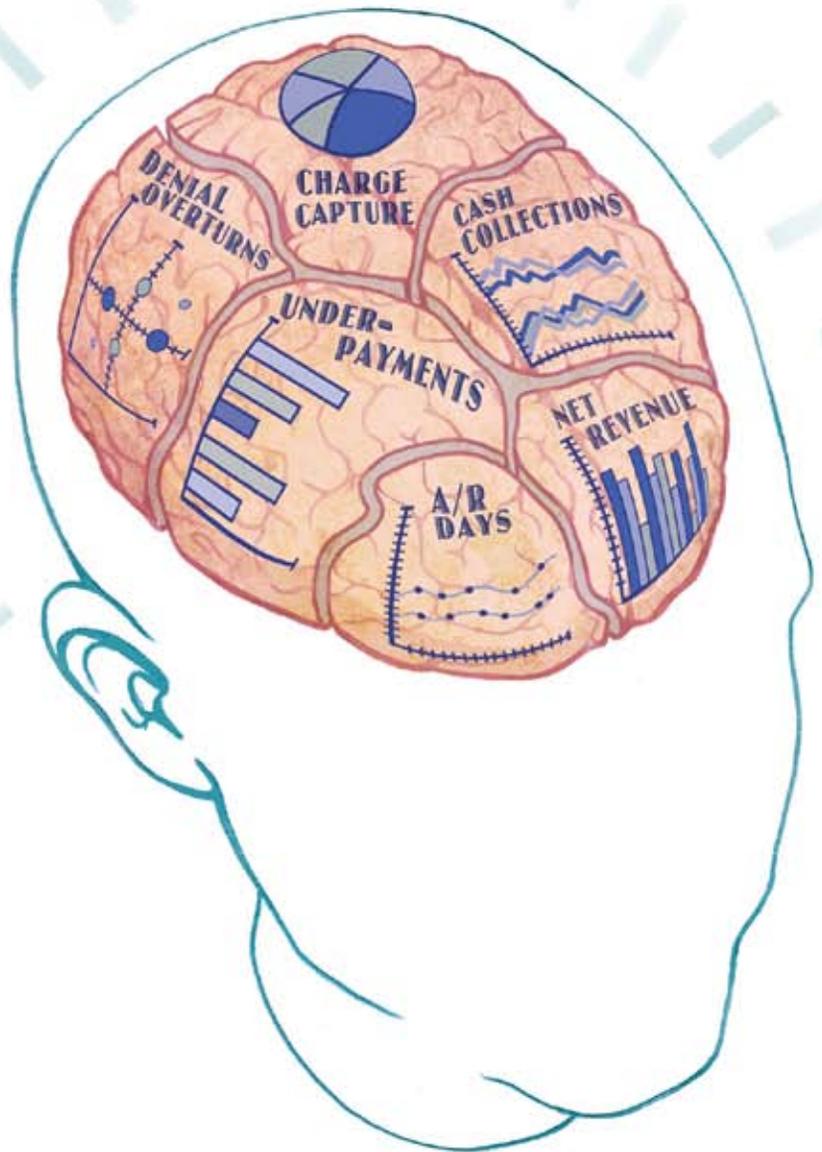
The following are some of the other major aspects of CMS' final IPPS rule:

- There will be a 2.0 percent cut in FY 2012 for changes in Medicare severity diagnosis related group documentation and coding, opposed to the proposed rule's recommended 3.15 percent cut.
- CMS said a prospective adjustment of a 3.9 percent cut toward documentation and coding continues to be necessary, so while the current 2.0 percent cut handles part of the rate, CMS might consider it feasible to make all or most of the -1.9 percent prospective adjustment in FY 2013.
- A Medicare spending per beneficiary measure will be employed in the Hospital Inpatient Quality Reporting program for FY 2012. This measure will assess Part A and Part B beneficiary spending from three days prior to a hospital admission through 30 days after the patient is discharged. Originally, in the proposed rule, the timeframe was 90 days, but CMS officials decided to keep the IQR program consistent with the 2013 Hospital Readmissions Reduction program.
- The rate-of-increase percentage for IPPS-excluded hospitals such as cancer and children's hospitals will be 3.0 percent. ■

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5 Ways to Improve a Hospital's Bottom Line Through the Revenue Cycle

By Bob Herman

A hospital's revenue cycle management team has to balance a large amount of tasks at once every day: preauthorization, precertification, underpayment collection, delays in payments, ICD-10 transition and more. With so many tasks to juggle at once, methods for improvement might get pushed on the backburner in the quest for simply finishing projects now. Becky Black, vice president of revenue cycle at Saint Joseph's Hospital of Atlanta, gives five ways any hospital can improve its revenue cycle, overall bottom line and efficiency.

1. Documentation of communication.

While it's common for hospitals to document all conversations and communication in a patient's case, it's also common for those documents to be misplaced. Saint Joseph's Hospital of Atlanta recently installed the Trace communication platform, which is a centralized portal that stores various forms of revenue cycle communication such as phone conversations, patient eligibility information, emails, incoming and outgoing faxes and more and indexes it by patient account.

Ms. Black says this has been a lifesaver for her hospital's revenue cycle because it allows them to go to one location to find all forms of communication regarding a patient's account and removes the "he said/she said" of reimbursement disputes. For example, the system can immediately pull up how the payor was contacted, who contacted the payor and if any authorization number on the patient's claim was obtained. In a way, it's like an electronic medical record for the revenue cycle as it eliminates paper records and hand-written notes and electronically stores all information on the business side of patient care. Within nine months of implementing this process, the hospital was able to use records to overturn more than 100 denials, resulting in nearly \$200,000 in cash collections.

While those are the primary benefits of that type of repository, Ms. Black says it also keeps the management team attentive. "It also underscores the professionalism of our staff," she says. "They know when they are using that system, they are being recorded as well, and it puts the onus on us to exhibit professionalism at all times."

2. Precertification of patients. Reviewing a patient's preadmission status blends the "business with the clinical excellence," Ms. Black says. Patient satisfaction isn't scored from the clinical side only, and making sure the patient is financially clear to come into the hospital puts all minds at ease. "What you do before the patient shows up is good for the organization and the patient," Ms. Black says. "It takes the financial worry off the patient, and it sets the stage on the front end for what the patient can expect to encounter on the clinical side." Additionally, by capturing this communication with patients on the front-end, hospitals can review conversations to ensure patients receive clear instructions before coming to the hospital.

Some younger patients take advantage of preregistration online, but Ms. Black emphasizes that a hospital must know its audience when it comes to utilizing technology to accomplish tasks such as patient preregistration. For example, some patients may want to sit with hospital staff and may prefer the direct contact to complete complex paperwork because that might fit their preference, whereas other patients may prefer to do this online without an interview process. "You have to gauge what your patients need," Ms. Black says. "We're not in the business these days of 'It's my way or the highway.' We are actually an extension of the marketing and business development efforts of the hospital."

3. Payment estimates. When a patient is scheduled for a hospital procedure, Ms. Black says it is paramount the team gives the patient an estimate of their out-of-pocket costs. Recording these conversations can also ensure estimates are communicated clearly prior to service, and if questions arise once the patient receives a bill, the hospital can reference those estimate records to resolve any misunderstandings. While giving estimates may be difficult for complex or exploratory procedures, she says patients who will be receiving planned procedures with case histories should get a reasonably accurate estimate.

For example, an estimate for a patient with UnitedHealthcare PPO receiving a hip replacement can be researched and refined, giving the patient a solid figure to contemplate. "Help the patient

if it's far enough ahead of time, and do it as soon as a procedure is scheduled," Ms. Black says. "Patients are footing a lot of costs out-of-pocket today and are shopping around at different hospitals, so every effort needs to be made to make such estimates as accurate as possible."

4. Meticulous managed care contract negotiation.

Ms. Black says in a perfect world, there would be one agreed-upon managed care contract methodology, but unfortunately, this is not a perfect world. To lower administrative costs, she says every good organization should review every managed care contract for clauses that are executable (e.g., the managed care company says they cannot pay for a certain type item unless it is billed a certain way even though doing so may not be a commonly accepted billing practice).

All accounts must also be religiously reviewed to detect underpayments and underpayment trends. When finding trends on underpaid claims, the revenue cycle team should take these back to contracting and then sit to review these disconnects with the payor. Documenting these discussions and the details of contract interpretation also assist in battling denied or underpaid claims. "Part of this is just the way that our current system works," Ms. Black says. "The question is: Is your staff good enough to seek and find all of these underpayment opportunities, or do you hand the underpaid claim off to someone else and pay them a finder's fee?"

5. Education on ICD-10. Ms. Black considers the conversion to ICD-10 as one of the biggest nail biters hospitals must confront today. Hospitals have to pay the inevitable costs to make the transition, but she says mass-scale education of hospital staff and clinical providers could help mitigate the hiccups that will occur when it goes into effect on Oct. 1, 2013. Weathering the storm for the first few months will be key to the hospital's bottom line, and the amount of work to do with ICD-10 simply should not be overlooked. "There are so many coding-specific things that need to be laid out. There's a lot to do, and you must retrain your hospital staff, especially your physicians and anyone else that documents within the record," she says. ■

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Survey: Roughly 7 out of 10 Hospitals Collect Less Than 30% of Payments at Point of Service

By Bob Herman

Approximately 70 percent of hospitals and health systems collect less than 30 percent of their payments at the point of service, according to a TransUnion Healthcare survey.

The survey polled more than 300 attendees of the Healthcare Financial Management Association's Annual National Institute Conference. Respondents said the two biggest challenges for collecting payments at the point of service are determining what is owed and training staff to ask for the payments.

Other highlights of the survey include the following:

In your opinion, what is the biggest challenge for patients when it comes to paying at the point of service?

- Patients are unprepared to make the payment: 36.79 percent
- Patients are uneducated on the option to pay at time of service: 25.47 percent
- Patient can't afford to pay at the time of service: 21.38 percent
- Patients are unwilling to make the payment: 16.35 percent

Of payments that go into back-end collections, what is the approximate recover rate at your hospital?

- Between 15 and 30 percent: 29.17 percent
- Between 0 and 15 percent: 22.76 percent
- Between 30 and 45 percent: 17.31 percent

- Not sure: 11.22 percent
- Between 45 and 60 percent: 9.29 percent
- Between 60 and 75 percent: 7.05 percent
- Between 75 and 90 percent: 2.24 percent
- More than 90 percent: 0.96 percent

In your opinion, how much of your net revenue in 2010 was lost to bad debt?

- Between 3 and 5 percent: 30.19 percent
- Between 1 and 3 percent: 26.73 percent
- Between 5 and 7 percent: 16.67 percent
- More than 7 percent: 16.35 percent
- Not sure: 6.6 percent
- Less than 1 percent: 3.46 percent ■

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HHS Announces New Bundled Payment Initiative

By Bob Herman

The Department of Health and Human Services has introduced a new program, Bundled Payments for Care Improvement, to improve healthcare for patients while they are in a hospital and after they are discharged.

Bundled Payments for Care Improvement, which was created by the Patient Protection and Affordable Care Act, will align payments for services across the entire episode of a patient's care instead of paying for services separately, the release said. For example, instead of a surgical procedure creating multiple claims from several different providers, the entire team of providers is compensated with a shared, bundled payment. HHS expects the program to improve the quality of care, incent physicians and hospitals to coordinate care and save money for Medicare.

There are four different models CMS will be

testing and developing for these bundled payments: Models 1, 2, 3 and 4.

In Model 1, the episode of care would be defined as the inpatient stay in a general acute-care hospital. Medicare will pay hospitals a discounted amount based on the Inpatient Prospective Payment System, and Medicare would pay physicians separately under the Medicare Physician Fee Schedule. Hospitals and physicians will then be able to share gains that result from better care coordination.

In Models 2 and 3, the bundle payments would include physicians' services, post-acute providers, related readmissions and other services such as clinical lab services. However, in Model 2, the episode of care would include the inpatient stay and post-acute care and would then end either a minimum of 30 or 90 days after discharge. In Model 3, the episode of care only beings at discharge from

the inpatient stay and would end no sooner than 30 days after discharge. Payments for both Models 2 and 3 will be made at the usual fee-for-service payment rates, and any reduction in expenditures will be paid to the participating providers to share.

In Model 4, CMS would create a single, prospectively determined bundle payment to the hospital that would encompass all services provided by the hospital, physicians and other practitioners during the inpatient stay. Those physicians and practitioners would submit "no-pay" claims to Medicare, and the hospital would then pay them out of the bundled payment.

Healthcare organizations interested in applying to the Bundled Payments for Care Improvement initiative must have submitted a letter of intent by Sept. 22, 2011, for Model 1 and by Nov. 4, 2011, for Models 2, 3 and 4. ■

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Trace by The White Stone Group is a browser-based software platform that captures communication from any medium — voice, fax or electronic — and indexes records by patient for efficient retrieval, sorting and routing. Nearly 400 hospitals nationwide are using Trace to capture information related to processes such as patient authorization, eligibility, scheduling, registration and more. Records are used to protect revenue, prove compliance and drive performance enterprise-wide.

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Director, Patient Financial Services

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VP, Revenue Operations

"Trace gives us an accurate and indisputable record of communication."

Chief Financial Officer

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Chief Administrative Officer

"Helps us resolve 'he-said, she-said' scenarios."

Director of Patient Financial Services

To find out why nearly 400 hospitals are using Trace to capture communication across the revenue cycle, visit TraceCommunication.com/Beckers.

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ANESTHESIA

The Case for Making Anesthesia the “Face” of Surgical Services

By Barbara Harris, Vice President of Operational Excellence, TeamHealth Anesthesia

Anesthesiologists are sometimes called the “lone wolves” of surgery. Often, these physicians work solo in the operating room and exist on the periphery of the ordinarily close-knit professional circles of surgeons and nurses. However, that doesn’t have to be the scenario. Hospitals should instead work to make their anesthesia team the “face” of the surgical program — when it comes to both patient interaction and coordination of care — because it can increase the efficiency of ORs and boost physician and patient satisfaction. Here are four key tenets of that strategy.

1. Know the patient. Typically a patient arrives at the hospital two hours before the scheduled surgery. He or she interacts with a nurse, a surgeon and an anesthesiologist — who usually pops in to say hello and check the patient’s chart to make sure he or she is ready to undergo anesthesia. But few patients realize that this person, who they met for three minutes, is the person responsible for their comfort and safety during surgery.

Anesthesiologists should take a few minutes to talk to their patients, tell them they’re glad to see them and know their patients’ names without consulting charts. Patients will visibly relax when somebody is telling them they’ve paid attention to their care. That can go a long way toward improving or maintaining patient satisfaction.

2. Take ownership of preoperative testing. Instead of becoming familiar with a patient only a couple hours before surgery, anesthesiologists should review the patient’s records and test results at least 72 hours prior to the day of surgery and interview those with high acuity or major co-morbidities. This gives the anesthesiologist an opportunity to evaluate the patient’s medical history and order any needed lab tests, consultations

or medications. Completing such tasks before the day of surgery helps ensure the patient receives the highest quality care and eliminates the need for last-minute tests or examinations that could delay or force cancellation of surgery.

Proper management of preoperative testing is most important for the first cases of the day because early morning delays cause backups that can affect other physicians, patients, equipment scheduling, OR time and a number of other issues throughout the day. By taking ownership of preoperative testing, anesthesiologists keep surgeries on schedule — a key component of keeping patients and physicians happy and maximizing the efficiency of a hospital’s OR. In most hospitals, surgery accounts for 55 percent or more of net revenues and 20 to 35 percent of the costs. Efficiency in the OR can help hospitals maximize profits.

3. Manage the continuum of care. In many hospitals that struggle with managing the continuum of care, nurse managers — who typically have tenure of only two and a half years — are the ones handling the process, which includes everything from patient transport to interacting and coordinating with surgeons. Many anesthesia practices lack seasoned managers and ultimately don’t have the expertise or gravitas to interact directly with the surgeons or collaboratively restructure a troubled department, and those departments frequently have angry surgeons. In those cases, the anesthesia team is on the sideline, and their day has been disrupted, too.

The anesthesia service should take the lead for managing the continuum of care for their patients. Given that anesthesiologists follow and track their patients’ health and comfort during their surgical stays, they are in a unique position to help solve problems, set processes and smooth protocols related to arrival, registration, admission, patient transport and the like. Effective management of patient throughput enhances patient and physician satisfaction, and this helps eliminate inefficiencies that can increase costs (for example, overtime pay) and reduce revenue (such as patients who tell their friends they had a lousy experience or surgeons who take their business elsewhere).

4. Make it a team effort. Using a “care team model” in anesthesia is one of the best ways to increase efficiency in the operating suite. In this model, rather than just using physicians, the anesthesia service also utilizes mid-level providers, such as certified registered nurse anesthetists or anesthesia assistants who can help the physician care for more than one patient at a time. With a care team model, hospitals are giving their anesthesiologists additional hands. For example, a patient can be in surgery while another is being prepped.

An anesthesia medical director should lead the entire anesthesia operation, providing oversight to the day’s events and handling the integration of emergency cases or other unexpected issues. Surgery is one of the most traumatic things people will experience throughout their lives. Anesthesiologists are the perfect people to bring comfort and security to a patient while playing a crucial role in OR efficiencies. They should view themselves as the face of surgery. ■

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The One Change ORs Should Make to Improve Efficiency: 5 Responses

By Sabrina Rodak

Improving an operating room's efficiency may seem daunting due to the number of factors involved, such as timing, patient safety, leadership and OR group cooperation. The following experts offer their opinions on the one change ORs should focus on to improve efficiency.

Q: What is the single most effective change an OR can make to improve efficiency and why?

Mark Antoszyk, Chief CRNA, Carolinas Medical Center NorthEast (Concord, N.C.): Leadership — without good leadership that has direct contact and respect, [the OR] will run by itself for a while but not long.

Houtan Chaboki, MD, Plastic Surgeon, George Washington Medical Faculty Associates (Washington, D.C.): Make each team member responsible and accountable. For example, don't allow surgeons to schedule for desired times if they are consistently inefficient.

Steven M. Gottlieb, MD, CEO, TeamHealth Anesthesia: The change that we've found to be most successful in improving OR efficiency has to do with leadership and reconsidering who is "conducting the orchestra" when it comes to managing perioperative care. One key factor to keeping surgeries running on time is making sure all patients' pre-admission tests are completed prior to the date of surgery...Anesthesiologists should take ownership of managing this process. Starting the first case(s) on time is another key to adhering to the OR schedule for the balance of the day. If just one or two cases start late, those delays can have sufficient ripple effects to cause a number of other problems or backups later in

the day. Finally, operating room turnaround times are paramount to the efficiency of a hospital's perioperative program. Needless to say, idle ORs are a missed revenue opportunity and can frustrate clinicians and patients, affecting satisfaction scores. To combat these issues, a hospital's anesthesia partner should have a protocol in place for shortening the time between cases — the most effective of which is properly utilizing an anesthesia care team model, which groups an anesthesiologist with one or more certified registered nurse anesthetists. This model allows the physician to care for more than one patient at a time throughout the perioperative continuum.

John Maa, MD, FACS, Assistant Professor, UCSF Department of Surgery: The single most helpful thing for ORs to do to enhance efficiency is to create an operating room suite dedicated for emergency procedures to accelerate hospital throughput, shorten hospital waits and reduce cancellations from a lack of inpatient beds. In many other countries, the typical hospital OR allocates two-thirds of its ORs for elective procedures and one-third for emergency procedures during the daytime.

Catherine Munoz, BSN, RN, CNOR, LNCC, Director of Perioperative Services, St. Vincent Medical Center (Los Angeles): Improving the pre-admitting and patient access processes are the key steps to reducing "day of surgery" delays and cancellations. Finding out the individualized needs of each patient and operating physician in advance can make the difference in getting those first cases of the day onto the operating room table on time. "First start," or first case of the day in each OR's scheduled line-up sets the tone for staying on time, which is the best indicator of efficiency and customer satisfaction. ■

HHS Review Could Impact Physician Supervision Requirements for Anesthesia Care

By Rachel Fields

The U.S. Department of Health and Human Services announced on Tuesday that CMS is developing a proposed rule to remove "obsolete or burdensome requirements" from the agency's regulatory structure, a move that could impact anesthesiology, according to an American Society of Anesthesiologists' news release.

ologists' news release.

The department will consider changes to hospital conditions of participation, including current physician supervision requirements imposed for anesthesia care. The department has received comments requesting that CMS eliminate these

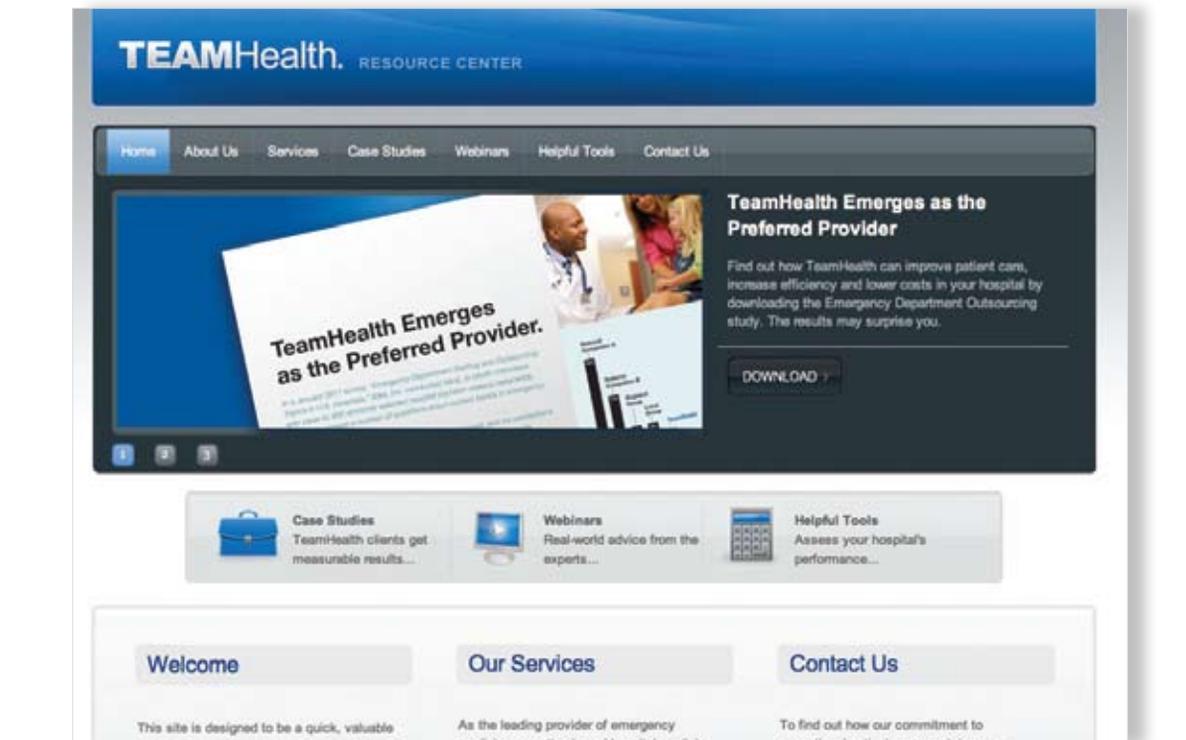
requirements, which are a component rule of the conditions of participation.

The American Society of Anesthesiologists has continued to support the physician supervision patient safety standard, according to the release. ■

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Private Equity Investing in Healthcare — 13 Hot and 4 Cold Areas

By Scott Becker, JD, CPA, Partner, Krist Werling, JD, MBA, Partner, and Holly Carnell, JD, McGuireWoods

Healthcare reform, the debt crisis and the continual regulatory changes that characterize the healthcare and life sciences industries have created certain shifts in the prospects of healthcare investments. This article briefly outlines 13 areas within healthcare in which private equity is still aggressively investing and several areas where things have slowed down.

13 Hot Areas for Healthcare Private Equity Investment

1. Hospitals and health systems. Hospitals and health systems seem to fit the category of “too big to fail” and are expected to enjoy relatively long-term government support. In addition to investment size, funds see opportunities in the hospital industry to consolidate and to monetize investments through debt or an IPO. Therefore, a growing trend in the United States is buying large not-for-profit systems and turning them into for-profit systems.^[1] Also, each large private equity fund appears to be investing or attempting to invest in a chain. Since November 2010, Cerberus Capital Management has purchased six hospitals owned by the Archdiocese of Boston for \$895 million, and since then, Cerberus’ Steward Health Care System has acquired four additional Massachusetts hospitals and has offered \$1.1 billion for Jackson Health System, a government-owned and financially distressed system in Miami.^[2] Additionally, in late 2010, Vanguard Health Systems acquired the Detroit Medical Center, a nine-hospital, not-for-profit health system (the Blackstone Group owns a roughly two-thirds stake in Vanguard). The trend of investing in hospitals and health systems also extends overseas (see discussion of investments in China and India below in Section 13).

Furthermore, a growing trend of health systems investing in health systems has developed.^[3] In Jan. 2011, five health systems announced they would privately invest in healthcare companies with The Heritage Group, a Nashville-based investment and consulting group; the fund set its fundraising target at \$200 million.^[4] Roughly one month later, Ascension Health, the nation’s largest Catholic health system, and Oak Hill Capital Partners announced the formation of Ascension Health Care Network, a fund to invest in distressed Catholic hospitals.^[5] The new fund reached its initial fundraising target of \$500,000, according to an SEC filing.^[6]

Notwithstanding private equity’s recent huge investment in this sector, some of the for-profit hospital chains are starting to see some headwinds due to reimbursement challenges and decreases in inpatient surgery volumes. In August, *The Wall Street Journal* reported that “Hospital companies feel the impact of deficit reduction efforts and their stock prices have fallen with concern regarding further reimbursement cuts.”^[7]

2. Hospital-based specialists. The demand for hospital-based specialists, including hospitalists, anesthesiologists and radiologists, continues to increase. In Sept. 2010, the Association of American Medical Colleges estimated that a shortage of at least 125,000 physicians will occur by 2025.^[8] This increase in demand, combined with a supply shortage, has led to a growing number of funds investing in practice management companies focused on managing networks of hospital-based specialists. Hospitalists (that is, doctors who are specialized in the care of patients in the hospital) can be effective in supporting hospital margins in the face of reimbursement models that pay for episodes of care rather than discrete services. In Feb. 2011, Cogent Healthcare merged with competitor Hospitalists Management Group to form the largest private hospitalist company in the country. The deal was financed by AEA Investors, who, according to the SEC filing, purchased Hospitalists Management Group in 2010 for an esti-

mated \$95 million. The growing demand for anesthesiologists is also fueled by the physician shortage. The aging population combined with the anesthesiologist shortage is resulting in a growing demand by hospitals and health systems for outsourced anesthesia. Finally, just as imaging technology grows in sophistication, so does the demand for radiologists. In 2010, Virtual Radiologic Corp. acquired top rival NightHawk Radiology Holdings Inc. for \$170 million. Virtual Radiologic went under private ownership in 2010 in a \$294 million sale to Providence Equity Partners.^[9] These practice management companies will likely continue to attract investors even in the face of downward pressure on reimbursement generally.

3. Ambulatory surgery center chains. There continues to be significant interest in the ambulatory surgery business. However, investors seem to be more interested in ambulatory surgery center chains with a specific focus, e.g. pain management, orthopedics or spine, than in general surgery chains. While the ASC industry faces certain challenges, tremendous consolidation opportunities and significant cost benefits associated with moving surgeries from inpatient to outpatient venues exist. In the last 24 to 36 months, TPG Capital invested in Surgery Centers of America and H.I.G. Capital invested in Surgery Partners. One year later, in Jan. 2011, Surgery Partners then bought NovaMed, AmSurg Corp. bought National Surgical Care and LLR Partners invested in a platform of fertility-driven ASC businesses. The key challenge ASCs will face is remaining profitable with downward pressure on reimbursement, particularly as the revised ASC standard rate-setting methodology took effect on Jan. 1, 2011. Ultimately, in 2011, ASCs will likely receive only 56 percent of what hospital outpatient departments receive for providing the same services.^[10]

4. Healthcare information technology (HCIT) and mobile health (mHealth). The amount that large health systems spend on HCIT remains incredible. In addition to government automation mandates in the form of Medicare reimbursement cuts for providers that fail to automate, HCIT remains a solid investment because of its ability to create the efficiencies that are necessitated by new reimbursement models such as payment bundling, accountable care organizations and medical homes. “There have been 297 announced or completed acquisitions of medical software companies in the past five years, with an average deal size of \$127.6 million and a typical premium of 45 percent, according to data compiled by Bloomberg.”^[11] According to Lisa Suennen, founding partner of Psilos Group Managers, “HCIT is once again the darling of the investment community.”^[12] Suennen notes that HCIT investing is again all the rage and notes five major economic drivers, including the passage of the HITECH Act and healthcare reform.^[13] *Modern Healthcare* also opined that “[h]ealthcare information technology, a significant strategic and capital priority in recent years, or services to manage spending or reduce medical errors or hospital readmissions are expected to be among the winners.”^[14] Andy Cowherd, managing director of the Peter J. Solomon Company, predicts in *peHub* that big payors and IT outsourcers may also benefit from healthcare reform because they may have the ability to handle the claims processing and recordkeeping for all of the people entering the system through Medicaid and insurance exchanges.^[15]

Some of the hottest areas of investment in this sector are in mHealth companies, data mining and analytics, speech recognition and revenue cycle improvement technologies. Venture capital investment in mHealth technologies has been strong and continue to gain momentum. Certain mHealth technologies connect providers and patients to provider-based EMR (Electronic Medical Record) systems, while others may stand alone or connect to payors,

medical devices or other individuals. Given the nascent age of the industry, many mHealth investments are by venture capitalists in relatively small technology companies. Mobilhealthnews.com reported that in the first quarter of 2011, investors announced or disclosed to the Securities and Exchange Commission nine investments in various mobile and wireless health startups. [16] Investors also have opportunities to capitalize in data analytics and data mining companies. Hospital electronic medical records systems, Medicare, Medicaid and health insurers are compiling an enormous amount of health data, which is not currently being used effectively to achieve physician decision support, cost savings and better patient outcomes.

5. Chronic disease. Increasingly, and as a recurrent theme, a huge amount of healthcare dollars are spent on chronic diseases, including asthma, diabetes, and COPD. In a May 2011 Healthcare Financial Management Association article, Harvard Business School Professor Regina E. Herzlinger opined that clear opportunities exist for hospitals to reduce costs, mostly in chronic disease and disabilities that are typically mistreated. [17] These opportunities are increasingly desirable as payment for hospital services begins to shift from traditional fee-for-service to episode-of-care based reimbursement. While chronic disease has not become an investment focus in its own right, there is tremendous interest from investors in companies with device, drug and HCIT technologies that can enable providers to realize the savings associated with successfully treating chronic conditions. Examples of chronic disease investments include Symmetric Capital's acquisition of a minority investment in BioRx, a national specialty pharmacy that provides customized therapies for chronic disease, in Nov. 2010; and in March 2011, medical device company Veniti announced that it raised \$13.5 million in Series A financing to acquire two additional medical device companies and began to commercialize multiple products focused on treating chronic venous disease. Investments in this space are not limited to the U.S. In Feb. 2011, U.K.-based medical device company Cellnovo raised £30 million (\$48.4 million) in a Series B financing round led by Edmond de Rothschild Investment Partners. Cellnovo develops and manufactures a mobile diabetes management system.

6. Cancer and oncology care. A tremendous amount of money is being invested in oncology-related products and services. Certain of these are in the radiation therapy sector, and others are in infusion therapy and physician practice management. On July 5, 2011, Kohlberg & Company announced it had acquired e+CancerCare, an operator of 16 outpatient cancer care centers. These centers provide services that include radiation

therapy, chemotherapy and PET/CT imaging in six states. An alternative trend within radiation therapy is the growth of proton therapy centers. In Feb. 2011, ProCure Treatment Centers, an operator of proton therapy centers, announced that it completed a \$40 million round of private equity financing led by Maverick Capital for continued development and growth. These centers are generally structured as joint ventures with hospitals, health systems and physicians.

7. Hospice sector. Private equity investors have displayed a renewed interest in the hospice sector. The hospice sector is benefiting from an aging population and also remains ripe for consolidation. According to a study by The Braff Group, hospice deal volume continues to roll with 10 transactions completed in the first quarter of 2011, equaling the second best quarterly tally posted in the fourth quarter of 2009. [18] The Braff Group predicts that with so many favorable market conditions aligned in hospices' favor, this trend is expected to continue throughout 2011, unless a reimbursement change or stumble by a high-profile provider bursts the current hospice bubble. [19] Examples of deals in this space include Apax Partners' investment in Voyager HospiceCare in 2004. Apax subsequently sold its stake in Voyager, a large U.S. provider of hospice and home health services, to Harden Healthcare in 2010. Cressey and Company has also made several investments in the home health and hospice sector. Cressey has invested in companies such as hospice campuses, which encompass home health and hospice care, and Homecare Homebase, a provider of home health and hospice agency computer software.

8. Dental practice management. We have seen many deals in the dental practice management space over the past five years. Dental practice management companies generally handle the business and administrative duties of running a dental office. The dental care industry is comprised mostly of group practices and sole practitioners that operate offices with significant capital and operating costs. The dental practice management model provides significant benefits to these providers, and private equity funds have recognized the opportunity and have invested in this sector. According to a report by Thomas A. Climo, PhD, titled "Emergence of the Dental Practice Management Company" published in *Dental Economics* magazine, "large dental practice management companies have put their hat in the private equity ring . . . and have found an accepting and willing avenue for funding their operations both as start-up or growing those operations through acquisition." [20] Mr. Climo further notes, "[a]s healthcare becomes increasingly expensive, increasing competition in the solo practitioner in-

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dustry continues and regulatory requirements increase, it is expected that this trend [of dental practice management companies running dental offices] should continue.”[21] Examples of investment in this space include American Capital’s investment in Dental Practice Management Company, Arcapita Bank’s acquisition of FORBA, and Freeman Spogli’s acquisition of a majority interest in Bring Now! Dental. In addition, in August of this year, Coast Dental Services acquired SmileCare, which is backed by Liberty Partners. This sector does face certain challenges. Notably, certain states seem to have grown cautious of the “corporate” model of practicing dentistry. These states may attempt to create roadblocks to the dental practice management model through various regulatory mechanisms, including Medicaid program participation rules and corporate practice of dentistry and dental clinic licensure laws.

9. Wound care. The wound care sector is generally comprised of medical supply and outpatient wound care management companies. A variable explosion of private equity investing in wound care firms has been occurring. Apax Partners bought Kinetic Concepts for close to \$5 billion, Edgewater Funds invested in Wound Care Solutions (also known as Diversified Clinical Services), Metalmark Capital Partners invested in National Healing Corporation and finally, in 2010, Cressey and Company acquired Wound Care Specialists. Bourne Partners, which focuses on life sciences investments and has invested in this space, attributes the growth in this sector, in part, to an aging population and the increased incidence of diabetes.[22]

10. Rehabilitation and addictive treatment. Private equity has made clear that a huge market in addiction treatment companies exists. In July 2011, for example, Clearview Capital invested in Pyramid Healthcare, which runs a chain of addiction clinics and halfway houses. Announcing the deal, a Clearview executive noted, “[u]nfortunately, the fundamental driving the business is that drug and alcohol abuse is growing.”[23] Paul Schatz, president and chief investment officer of Heritage Capital, also notes that “[i]n more difficult times, drug and alcohol addiction go up.” Also this year, both Bain Capital and Advent International reportedly bid on RBS’ Priory Group based in England with Advent eventually agreeing to a deal.[24] The Priory Group of rehabilitation centers are the most well known in the U.K. Bain also invested in marquee name Sierra Tucson a few years back. Separately, American Capital bought for \$79 million The Meadows of Wickenburg, a well-known treatment facility. State Medicaid programs cover much of the cost of treatment in drug and alcohol abuse clinics.

11. Physical therapy. Investors have been and continue to be interested in the outpatient physical therapy business. Physical therapy companies with a healthy payor mix and diverse referral base are attractive to private equity funds. In general this sector is doing well partially because payors are demanding that physicians first refer to physical therapists rather than refer cases for surgery due to cost containment efforts – this applies both to private payors and workers compensation. Examples of deals in this space include Water Street Partners, who in 2007 acquired Physiotherapy Associates from Stryker Corporation and shortly thereafter, facilitated a merger with Benchmark Medical to create a large presence in the physical therapy space. In addition, in July 2011, Ontario Municipal Employees Retirement System, Toronto, acquired physical therapy provider Accelerated Holdings from Gryphon Investors who bought Accelerated in March 2008.

12. Revenue cycle companies. According to Duff & Phelps, “RCM providers are attractive investment opportunities for both strategic and financial buyers.”[25] Duff & Phelps further notes that “Strategic buyers are actively seeking acquisition candidates that expand their RCM offerings to create end-to-end customer solutions.”[26] However, the opportunities for automated RCM solutions are at the expense of the hardcore revenue cycle management companies that actually have people doing the work of revenue cycle management. According to Duff & Phelps, “automation results in a permanent shift from labor to capital and significantly reduces variable cost to healthcare providers.”[27] The RCM industry has been subject to widespread consolidation in recent years. Duff & Phelps published a sam-

ple of RCM companies that are owned by private equity funds – a list that is 160 deep.[28] Recently, *The Wall Street Journal* reported that Blackstone Group agreed to buy Emdeon for about \$3 billion, taking the healthcare billing firm private again after two years as a public company.[29]

13. Certain overseas markets. An increased interest in investing in healthcare projects in China and India exists. *The China Daily* recently reported that investment in private hospitals recently became increasingly popular among venture capital and private equity firms as a result of policy incentives and the huge potential in China.[30] *The China Daily* reported that five different medical institutions have recently received about 500 million yuan (nearly \$80 million) in private equity and venture capital investments.[31] Bain observed in its *India Private Equity Report 2011* that India’s fundamentals will continue to attract PE investors and bolster the confidence of limited partners.[32] However, Bain also noted that the biggest barrier holding India back is the lack of regulatory support.[33] Bain reported that in 2010, healthcare PE deals that closed in India were valued at \$600 million but that deals that closed represented just 1 percent of companies attracting PE interest.[34] Survey respondents voted healthcare as one of the top three sectors in India for investing during the next two years (BFSI and consumer products were also in the top three).[35] On the forefront, in 2007 Apax Partners purchased an 11.5 percent stake in Apollo Hospitals, a leading hospital chain in India.

4 Slowing Areas for Healthcare Private Equity Investment

While certain areas are hot, some areas seem to be slowing down significantly.

1. Home health. A hospital executive recently remarked that nearly 420 new Medicare-certified home agencies or hospice agencies are within one mile of its hospital. Despite this huge volume of companies, flat reimbursement from Medicare and an increasingly negative tone regarding rates from MedPAC have led to a decrease in deals in this space. According to The Braff Group, Medicare-certified home health transactions plunged 50 percent in the first quarter of 2011 as buyers and sellers alike turned inward to respond to 5 percent reimbursement cuts that became effective Jan. 1.[36] The Braff Group predicts that with CMS and MedPAC calling for further reductions, the sector is subject to substantial risk overhang, which has made buyers extremely cautious.[37] In addition to reimbursement woes, CMS’ “36 month rule” has impeded consolidation in this sector. The “36 Month Rule” is applicable to home health agencies that participate in the Medicare Program, impacts a change in majority ownership of an agency by sale, which occurs 36 months after (i) the agency’s initial enrollment in Medicare, or (ii) the agency’s most recent change in majority ownership. In such situations, unless an exception applies, the agency’s Medicare Provider Agreement and Medicare billing privileges do not convey to the new owner, and the new owner must instead enroll in the Medicare program as a new home health agency and obtain a state survey or accreditation. Excluding a surge in deal flow in the third quarter of 2010, Medicaid home health has averaged one to two deals per quarter since the end of 2008.[38]

2. Nursing homes. *The Wall Street Journal* reported that nursing homes were the biggest losers among healthcare providers following the agreement to raise the debt ceiling.[39] CMS announced it would drop nursing-home payments by 11.1 percent in response to unexpected increases in payments this fiscal year, after the agency had tweaked coverage rates last year.[40] Similarly, state Medicaid programs are limiting payment increases. The cuts had an immediate negative impact on the market value of operators Sun Healthcare Group, Skilled Healthcare Group and Kindred Healthcare. Gary Taylor, a Citigroup analyst, said, “It’s difficult to qualify a level at which we would be buyers of nursing home stocks after the worst possible scenario for reimbursement rates.”[41]

3. Life sciences. Some concern seems to exist regarding investment in life science companies. *The Wall Street Journal* observed in the wake of the agreement to raise the debt ceiling, “medical device companies [in addi-

tion to nursing homes and hospitals] were also feeling the heat.” [42] Medical device companies have been under pressure from aggressive hospital bargaining. In addition to pricing issues, the FDA’s plan to revamp the 510(k) process, combined with the IOM’s recommendation that the 510(k) process is beyond repair and the FDA should just start over,[43] has done little to quell the uncertainty in this sector. However, as noted above, certain device companies, including those focused on chronic disease management and wound care, continue to receive interest from investors. In terms of biotech, the industry faces a fair degree of uncertainty due to factors such as healthcare reform, barriers to early-stage financing of innovation and an increasingly hostile reimbursement environment. According to Prequin, an independent research firm focusing on alternative assets, “[a] number of investors in biotechnology are approaching investments in the private equity asset class on opportunistic basis.”[44] While investments in biotech have slowed over recent years, an appetite for investments still exists in this space. EisnerAmper’s private equity executive’s survey for spring 2011[45] reported that 38 percent of respondents showed interest in life sciences/biotech (compared to 81 percent who expressed an interest in healthcare).[46]

4. Imaging. Investment in the imaging sector has slowed in recent years. The Deficit Reduction Act created deep reimbursement cuts for diagnostic imaging centers. The DRA cuts, together with an overbuilt sector, led to decreased investment during the later half of the last decade. In addition, according to RadNet, a large operator of freestanding diagnostic imaging facilities, imaging volumes are down for the first time in 10 years.[47] RadNet cites concerns over radiation exposure, the prevalence of radiology benefit managers and decreases in visits to primary care and specialist physicians in the last 12 months as causes of these volume decreases. [48] However, despite its challenges, the sector is highly fragmented and, with the exception of certain dominant regional chains, is ripe for consolidation. RadNet opines that small providers’ fear of survival is driving acquisition multiples downwards and observes that these operators are struggling because of increased cost structure, lack of leverage in network contracting and limited access to capital.[49] ■

[1] Evans, *supra*.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] Melissa Korn and Jon Kamp, “Healthcare Companies are Infected by Severe Case of Washington Jitters,” *The Wall Street Journal*, August 2, 2011, <http://online.wsj.com/article/SB10001424053111903520204576482161446251504.html/>

[8] Kevin B. O’Reilly, “New medical schools open, but physician shortage concerns persist,” *amednews.com*, March 29, 2010, <http://www.ama-assn.org/amednews/2010/03/29/prl20329.htm>.

[9] Sam Black, “Virtual Radiologic Corp. to be acquired by private equity firm for \$294M,” *Minneapolis / St. Paul Business Journal*, May 17, 2010, <http://www.bizjournals.com/twincities/stories/2010/05/17/daily3.html>.

[10] ASC Association, “Medicare’s 2011 Payment Rates — Are You Prepared?,” *Focus*, November/December 2010.

[11] Alex Nussbaum and Jason Kelly, “Blackstone Group Agrees to Acquire Medical-Biller Emdeon for \$3 Billion,” *Bloomberg*, August 4, 2011, <http://www.bloomberg.com/news/2011-08-04/blackstone-to-buy-health-care-biller-emdeon-in-deal-valued-at-3-billion.html>.

[12] Lisa Suennen, “The Second Coming of Healthcare IT,” *Venture Valkyrie*, July 26, 2011, <http://www.venturevalkyrie.com/2011/07/26/the-second-coming-of-healthcare-it/2468/>.

[13] *Id.*

[14] Melanie Evans, “Building Equity,” *Modern Healthcare*, May 2, 2011, <http://www.modernhealthcare.com/article/20110502/MAGAZINE/110429981>.

[15] Posting of Andy Cowherd to PEHub, March 23, 2010, <http://www.pchub.com/67023/what-does-healthcare-reform-mean-for-healthcare-investing/>.

[16] Brian Dolan, “The 9 wireless health investments so far this year,” *MobiHealthNews*, April 14, 2011, <http://mobihealthnews.com/10721/the-9-wireless-health-investments-so-far-this-year>.

[17] Jeni Williams, Healthcare Financial Management Association, “A New Road Map for Healthcare Business Success,” May 2, 2011, <http://www.hfma.org/Templates/Interior-Master.aspx?id=26425>.

[18] The Braff Group, “Health Care Service M&A Activity Up 9.2%,” *Perspectives*, 2011 first quarter, <http://www.thebraffgroup.com/Articles/articlespdfs/perspectives/Q12011.pdf>.

[19] *Id.*

[20] Thomas A. Climo, Ph.D., “The emergence of the dental practice management company,” *Dental Economics*, September 2009, <http://www.dentaleconomics.com/index/display/article-display/369523/articles/dental-economics/volume-99/issue-9/features/the-emergence-of-the-dental-practice-management-company.html>.

[21] *Id.*

[22] Bourne Capital Partners, LLC, *Advanced Wound Care – Sector Report*, August 2008, <http://www.bournepartners.com/FileLib/Wound%20Care%20Update.pdf>.

[23] Rob Varnon, “Addiction clinic draws Greenwich private equity firm,” *Connecticut Post*, July 11, 2011, <http://www.ctpost.com/news/article/Addiction-clinic-draws-Greenwich-private-equity-1461692.php>

[24] *Id.*

[25] Duff & Phelps, *Industry Insights, Healthcare Services: Revenue Cycle Management*, summer 2010, http://www.duffandphelps.com/sitecollectiondocuments/reports/Healthcare_RCM_June2010.pdf.

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] Shasha Dai, “UPDATE: Blackstone To Acquire Emdeon For \$3 Billion,” *The Wall Street Journal*, August 4, 2011, <http://online.wsj.com/article/BT-CO-20110804-719221.html>.

[30] Cai Xiao, “Medical Investment is Just What the Dr. Ordered,” *China Daily U.S.A.*, July 16, 2011, http://usa.chinadaily.com.cn/epaper/2011-07/16/content_12916287.htm.

[31] *Id.*

[32] Bain & Company, *India Private Equity Report 2011*, April, 2011, <http://www.bain.com/publications/articles/bain-india-private-equity-report-2011.aspx>

[33] *Id.*

[34] *Id.*

[35] *Id.*

[36] The Braff Group, “Health Care Service M&A Activity Up 9.2%,” *Perspectives*, 2011 first quarter, <http://www.thebraffgroup.com/Articles/articlespdfs/perspectives/Q12011.pdf>.

[37] *Id.*

[38] *Id.*

[39] Korn and Kamp, *supra*.

[40] *Id.*

[41] *Id.*

[42] *Id.*

[43] See Institute of Medicine of the National Academies, *Medical Devices and the Public’s Health: The FDA 510(k) Clearance Process at 35 Years*, July 29, 2011, <http://www.iom.edu/Reports/2011/Medical-Devices-and-the-Publics-Health-The-FDA-510k-Clearance-Process-at-35-Years.aspx>.

[44] Posting of Bogusia Glowacz to Prequin Blog, “LPs Investing in Biotechnology-Focused Private Equity Funds,” August 2, 2011, <http://www.prequin.com/blog/101/4022/biotechnology/>.

[45] The 107 respondents, all from funds, were primarily general partners as well as managing, executive and other directors (62 percent). The other respondents were a cross-section of principals, CFOs, COOs and vice presidents, among other senior positions.

[46] EisnerAmper, *The Pulse of Private Equity, Private Equity Executives Survey*, spring 2011, http://www.eisneramper.com/uploadedFiles/Resource_Center/Articles/Articles/EisnerAmperPulse_Spring2011.pdf.

[47] RadNet Inc., *Investor Presentation*, June 2011, http://www.radnet.com/pdf/investor_presentation.pdf.

[48] *Id.*

[49] *Id.*

Hospital & Health System Transactions

Meridian, Miss.-based **Anderson Regional Medical Center** and Philadelphia, Miss.-based **Neshoba County General Hospital-Nursing Home** officially entered into an affiliation. The affiliation gives NCGH access to ARMC's comprehensive cancer center.

The Federal Trade Commission approved Nashville, Tenn.-based **Ardent Health Services'** purchase of **SouthCrest Hospital** in Tulsa, Okla., and **Claremore (Okla.) Regional Hospital** from Franklin, Tenn.-based **Community Health Systems**.

Auburn Memorial Hospital in Syracuse, N.Y., issued a request for partnership proposals to five hospitals: Syracuse-based **SUNY Upstate Medical University**, **Crouse Hospital** and **St. Joseph's Hospital and Health Center** and Rochester-based **Strong Memorial Hospital** and **Rochester General Health System**.

Baptist Memorial Health Care in Memphis, Tenn., will now have control over Oxford, Miss.-based **Baptist Memorial Hospital-North Mississippi** after the city of Oxford and Lafayette County approved its sale.

Franklin, Tenn.-based **Capella Healthcare** signed a letter of intent to explore a partnership with 45-bed, physician-owned **Muskogee (Okla.) Community Hospital**.

After losing \$4 million last year, officials at **Christ Hospital** in Jersey City, N.J., said they are in negotiations to have Ontario, Calif.-based **Prime Healthcare Services** buy their hospital.

Community Health Systems based in Franklin, Tenn., announced its intent to acquire Scranton, Pa.-based **Moses Taylor Health Care System's** assets.

Geisinger Health Systems in Danville, Pa., and **Community Medical Center** in Scranton, Pa., are planning to merge. The Pennsylvania attorney general's office will review the impending transaction.

Greenville (S.C.) Hospital System and Columbia, S.C.-based **Palmetto Health** are considering collaboration opportunities, after Fitch Ratings downgraded Greenville Hospital System's bond ratings from AA to AA-.

The Federal Trade Commission approved the partnership between Stockbridge, Ga.-based **Henry Medical Center** and Atlanta-based **Piedmont Healthcare**.

HCA reached a definitive agreement to acquire the Colorado Health Foundation's shares of its Denver-based joint venture, **HCA-HealthOne**. The hospital operator will purchase the foundation's remaining ownership interest for \$1.45 billion.

The Illinois health board signed off on a proposed affiliation between Des Moines-based **Iowa Health System** and Peoria, Ill.-based **Methodist Health Services**.

Leaders with Kansas City, Kan.-based **Kansas University Hospital**, **KU Medical Center** and **KU Physicians** are set to begin negotiations to iron out a new affiliation agreement. The current agreement expires Sept. 30, 2012, and the parties will most likely begin meeting later this year.

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

The board of directors at Henderson, N.C.-based **Maria Parham Medical Center** and **Duke LifePoint Healthcare** signed an agreement to jointly own and operate MPMC. Duke LifePoint will own 80 percent of the affiliation and invest \$45 million in capital improvements at the hospital over the next 10 years, while MPMC's debt will also be eliminated.

MedCath sold Heart Hospital of New Mexico to Lovelace Health System in Albuquerque and Arkansas Heart Hospital to **AR-MED**, which is majority owned by Bruce Murphy, MD, a physician affiliated with Little Rock Cardiology Clinic and a current investor in the Arkansas Heart Hospital.

Flint, Mich.-based **McLaren Health Care** and **Northern Michigan Regional Health System** in Petoskey, Mich., entered into an agreement to explore a system affiliation.

Georgia Attorney General Sam Olens approved Albany, Ga.-based **Phoebe Putney Health System's** acquisition of **Dorminy Medical Center** in Fitzgerald, Ga.

Mokena-based **Provena** and Chicago-based **Resurrection** reached a merger agreement. The deal would create the largest Catholic health system in Illinois.

Saint Mary's Health Care in Grand Rapids, Mich., and **Mercy Health Partners** in Muskegon, Mich., are set to merge into a new organization called Mercy Health. Both health systems are owned by **Trinity Health**.

Saints Medical Center in Lowell, Mass., entered into an asset purchase agreement to become a part of Boston-based **Steward Health Care**. As part of the affiliation agreement, Steward will provide Saints Medical Center with \$5 million immediately for capital needs and a capital commitment of a \$35 million investment over five years, among other conditions.

Temple, Texas-based **Scott & White Healthcare** signed a 20-year affiliation agreement with **Texas Children's Hospital**, also in Temple, to enhance the quality of pediatric care.

Pennsylvania's Department of Health and Attorney General issued final approval on the merger between **Shamokin Area Community Hospital** in Coal Township, Pa., and **Geisinger Medical Center** in Danville, Pa.

The potential merger between Nashville, Tenn.-based **Vanguard Health Systems** and Chicago-based **Holy Cross Hospital** was canceled.

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Hospital & Health System Executive Moves

Baltimore Washington Medical Center in Glen Burnie, Md., named **Ronald J. Andro** as the medical center's new senior vice president and COO.

Eric Beyer was chosen to lead as president and CEO of Tufts Medical Center in Boston, effective Oct. 1.

Cleveland Clinic officials announced the promotion of **Robert Weil**, MD, and **Brian Donley**, MD, to presidents for Lakewood (Ohio) Hospital and Lutheran Hospital in Cleveland, respectively, beginning Jan. 1, 2012.

Nina Dusang joined Tuscaloosa, Ala.-based DCH Health System as vice president of finance and CFO.

National Surgical Hospitals, based in Chicago, appointed **Bryan Fisher** president and COO of the company.

Jeffrey A. Flaks, executive vice president and COO of Hartford (Conn.) Hospital and executive vice president of Hartford HealthCare, was appointed president and CEO of Hartford Hospital.

Gary Fletcher was appointed COO for St. Luke's Health System in Boise, Idaho.

Terry Forde was named executive vice president and COO of Adventist HealthCare, based in Rockville, Md.

SSM Health Care named **Chris Howard** president and CEO designate of SSM Health Care-St. Louis, effective Sept. 4.

Provena Health officials promoted Executive Vice President and COO **Beth Hughes** to president and CEO of Joliet, Ill.-based Provena Saint Joseph Medical Center.

Reynold Jennings was named president and CEO of WellStar Health System, based in Marietta, Ga.

David McGrew was appointed CFO of Santa Clara Valley Health and Hospital System in Santa Clara County, Calif.

Stephen Newman, MD, COO of Dallas-based Tenet Healthcare Corporation, will be retiring in mid-2012.

Sister Mary Norberta, president and CEO of St. Joseph Hospital in Bangor, Maine, will be stepping down after 29 years of leadership at the helm.

Jeffrey Norman, CEO of St. Joseph Medical Center in Towson, Md., announced his resignation "without explanation" amid the hospital's stent controversy. **Charles Neumann** will succeed Mr. Norman.

Mark O'Neill, CFO of Quincy (Mass.) Medical Center, was promoted to CEO.

Methodist Health System named **John Phillips** president of Methodist Mansfield (Texas) Medical Center.

Sutter Medical Center in Sacramento appointed **Carrie Owen Plietz** to serve as the hospital's CEO.

Ramanathan Raju, MD, was appointed to lead Cook County Health and Hospitals System in Chicago.

Doug Strong, CEO of University of Michigan Hospitals and Health Centers in Ann Arbor, Mich., was reappointed for a second five-year term.

William Thompson was named president and CEO of St. Louis-based SSM Health Care.

Jeffrey Van De Kreeke, senior vice president of finance for Milwaukee-based Froedtert Health, was promoted to CFO.

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