SPECIAL LISTS ISSUE: 30 of the Largest Hospital Systems in America & More!

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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

September/October 2011 • Vol. 2011 No. 7

The Quiet Takeover: Insurers Buying Physicians and Hospitals

By Molly Gamble

Payors might provide more than reimbursement in the next few years — they may be signing the check to buy your hospital or the physicians that drive your referrals.

Payors buying physicians

Two related but distinct trends are emerging, and quietly: insurers buying physician groups and insurers buying hospitals. The first

continued on page 8

Patient Experience: An Increasingly Critical Hospital Indicator

By Lindsey Dunn

Hospitals have long tracked patient satisfaction ratings, but they didn't always carry great significance. While all hospitals want happy patients, hospitals have been historically plagued with the "doctor knows best" mentality — a mentality where clinical outcomes outweigh "touchy-feely" indicators such as patient satisfaction or overall patient experience.

However, in recent years, some leading institutions have begun to focus more heavily on providing an outstanding patient experience. Part of this has been driven by the public reporting of Hospital Consumer Assessment of Healthcare Providers and Systems scores, which will soon be

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Changes Ahead: Medicare IPPS 2012 and What It Means for Hospitals

By Molly Gamble

Medicare and hospitals go hand in hand. Hospital payments account for the greatest share of the federal program's spending, and Medicare is the largest payor for hospital services, comprising a significant portion of most hospitals' revenue. As of Oct. 1, though, hospitals will operate under a revised inpatient prospective payment system — one that could prove costly to many hospitals.

The changes to the IPPS for fiscal year 2012

Imagine if the method of assessing individual taxes changed and the government scrapped its traditional income-based approach for a model that taxed Americans based upon their personal caliber.

This may sound far-fetched, but healthcare leaders might share a strange yet

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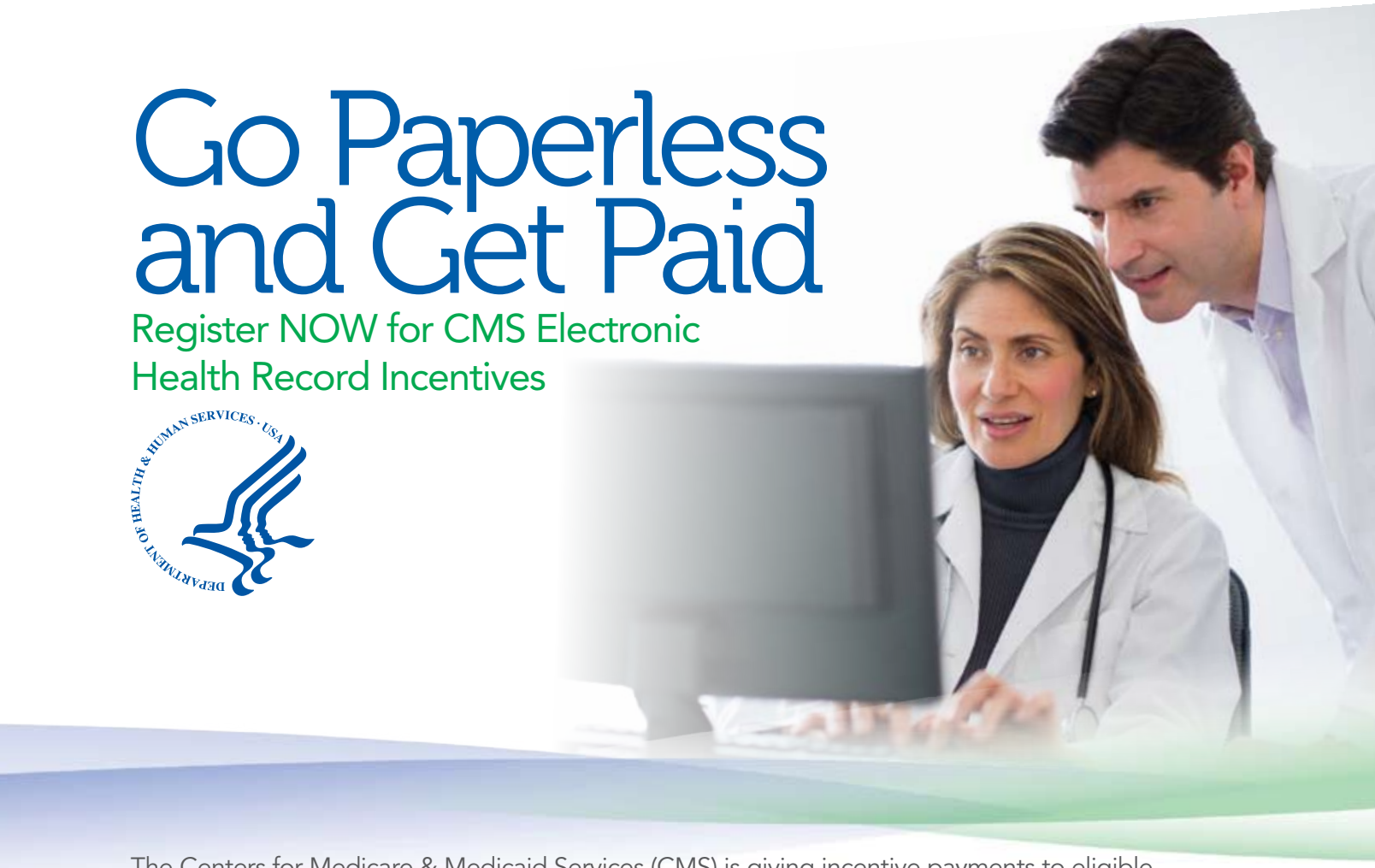

The Centers for Medicare & Medicaid Services (CMS) is giving incentive payments to eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of certified electronic health record (EHR) technology.

Incentive payments will include:

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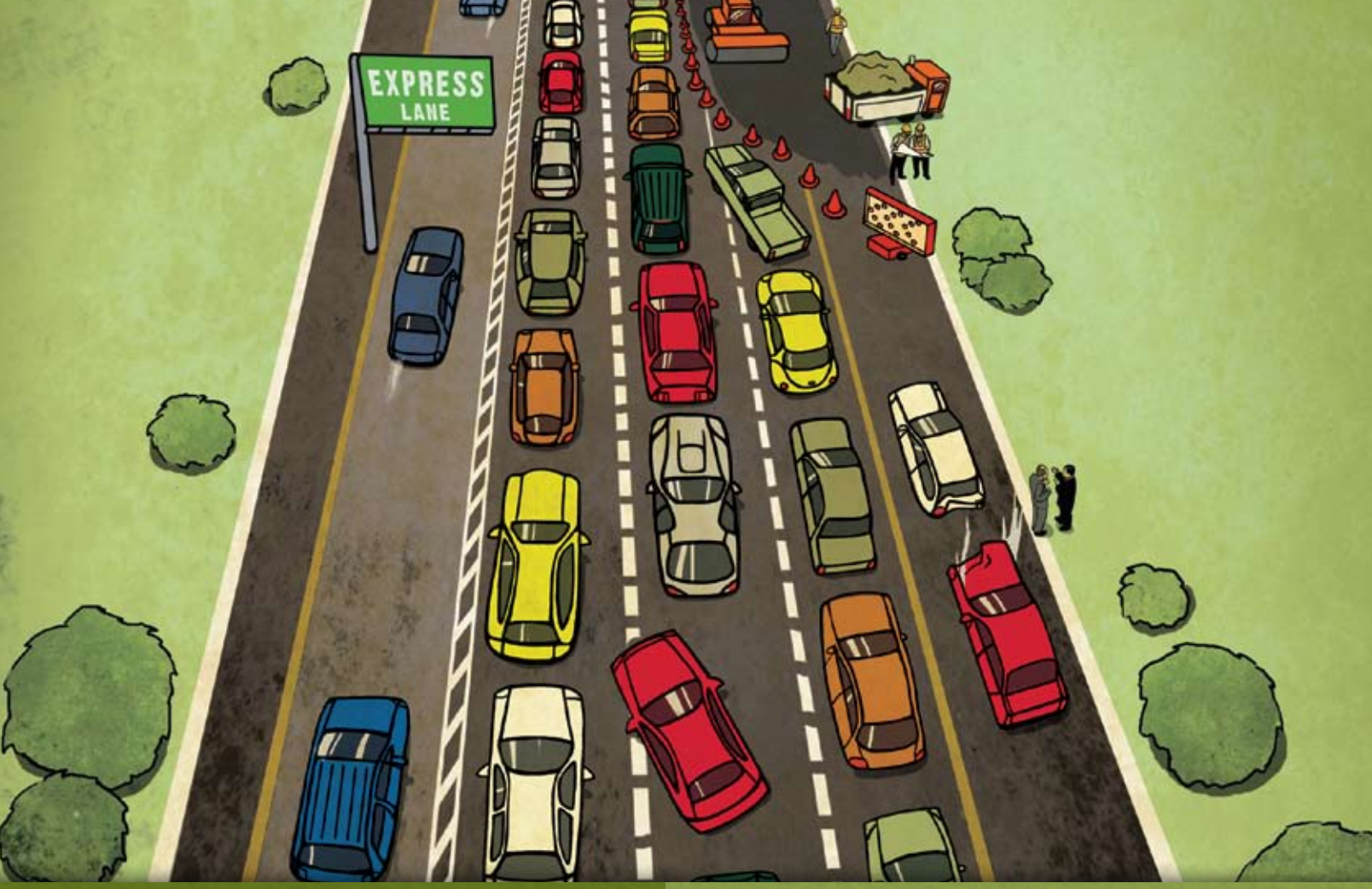

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Official CMS Industry Resources for the ICD-10 Transition
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FEATURES

Publisher's Letter

The Evolution of Physician Alignment; Becker's Hospital Review CEO/CFO Annual Strategy Webinar

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

1. The Evolution of Physician Alignment. Core options for alignment. Hospitals generally look at three core options for aligning with physicians. These include (1) practice acquisitions coupled with ongoing employment, (2) collaborative hospital financial relationships such as joint ventures, call coverage, recruiting assistance, service line management and (3) finding ways to work with physicians that have complete financial independence. However, the era of complete independence seems to be moving towards extinction. According to a recent study by Accenture, only 33 percent of physicians will remain truly independent by 2013. Thus, much effort is placed on the employment integrated model and hybrid relationships, of which there are a variety. Overall, though, more and more hospitals seem to be focused on executing a strategy that includes a vertically integrated delivery system, which can be achieved through acquisition and employment as well as residency hiring. However, building a strong bottom-up program through residency hiring can take a decade or more. As a result, systems are increasingly focused on employment and acquisitions.

Physician employment. While many systems today use a mix of both the employment and hybrid models to approach their physician alignment strategy, even more physician employment is on the horizon. A study by the Medical Group Management Association reported that 55 percent of medical practices were hospital owned as of 2009. In 2005, the majority of practices (66 percent) were physician owned.[1] Additionally, a Merritt Hawkins survey of hospital leaders revealed the following:

- 74 percent say they plan to employ a greater number of physicians in the next 12 to 36 months
- 70 percent say they have received increased requests from physician group for employment
- 61 percent plan on acquiring medical groups in the next 12 to 36 months[2]

Alignment critical to hospital survival. It has been noted "Only hospitals that are tightly aligned or integrated with critical mass of physicians will be able to organize their delivery system to meet payer/consumer demands for price, quality, efficiency and community services. Hospitals that lack a strong relationship with a group of line doctors will not survive on their own."[3]

The acquisition and employment of physicians requires a thought-out process executed by outstanding senior leadership. There continues to be increased scrutiny of such relationships from a federal standpoint. This comes in the form of cases that allege unreasonable compensation being paid by hospitals to employed physicians and situations where purchasers of practices were being viewed as paying more than fair market value. For more information on this issue, see our October special issue of *Becker's Hospital Review*, which will contain a detailed discussion of the legal issues related to acquisition of physician practices.

2. 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/CFO Strategy Webinar – 2012" will take place on Nov. 8th. Please watch our E-Weekly for more details and information on how to register.

3. 18th Annual Ambulatory Surgery Centers Conference. *Becker's ASC Review's* 18th Annual Ambulatory Surgery Centers Conference — Improving Profitability and Business and Legal Issues conference will take place on Oct. 27-29, 2011 in Chicago at the Westin Michigan Avenue. This year's keynote speakers include legendary journalist Sam Donaldson, former NBA star Bill Walton and Adrian Gostick, employee engagement expert and author of "The Carrot Principle." The conference features 90 sessions and 132 of the best speakers on ASC industry issues. To register for the conference, call (703) 836-5904 or email registration@ascassociation.org. More information on the conference is available at www.BeckersASC.com.

* * *

Should you have any questions or can we be of any help, please contact Scott Becker, publisher of *Becker's Hospital Review*, at sbecker@beckershealthcare.com or call (312)750-6016.

Very truly yours,

Scott Becker

1 Medical Group Management Assoc., *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data 26* (2010).

2 Merritt Hawkins, Health Reform and the Decline of Physician Private Practice: A White Paper Examining the Effects of the Patient Protection and Affordable Care Act on Physician Practices in the United States (2010).

3 Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment, A Governance Institute White Paper (2008).

The Quiet Takeover: Insurers Buying Physicians and Hospitals
(continued from page 1)

development has been subtle. Four of the five largest health insurers have increased physician holdings in the past year, according to a *Kaiser Health News* report. Recently, UnitedHealth Group has been buying medical groups and launching physician management companies. The same report said the strategy has stirred little controversy largely because few people know about it. One physician group mentioned in the report learned of UnitedHealth's new strategy only when it received a phone call from the company with an offer.

So far, UnitedHealth is the payor with the largest revenue to buy physicians, but it is not the first. CIGNA Medical Group launched its CareToday clinics in 2006, providing "an alternative to traditional [physicians'] offices" in Arizona. Last December, Louisville-based Humana purchased Concentra, an urgent-care system based in Addison, Texas. In early June, Indianapolis-based WellPoint acquired CareMore Health Group, a health plan operator based in Cerritos, Calif., that owns 26 clinics.

"There is definitely a national landgrab over primary care physicians," says Ted Schwab, partner at the Health and Life Sciences practice of Oliver Wyman, an international management consulting firm. This creates a clash between the insurance industry and hospital industry as both fight to control primary care, the epicenter of care management. "We work with insurance companies all over the country, and every single one of them is discussing this in their board rooms. Some are very aggressive, some have decided not to do it," says Mr. Schwab.

The model poses a natural threat to providers, particularly hospitals. OptumHealth, UnitedHealth's subsidiary, has said its physician networks serve all players in a health system, including rival health plans with policyholders who use the same physicians. Still, the CMO of a physician group in Nevada declined UnitedHealth's offer, saying it would compete directly with the group's business model, according to the same *Kaiser Health News* report. Primary care physicians are already in high-demand, and by acquiring them in certain markets, insurers could potentially wrest control of entire health systems by influencing referrals — whether that is an explicit intention or not.

Payors buying hospitals

A proposed deal in Pittsburgh has proven insurers can take their acquisitions one step further and buy entire hospital systems. While the concept may be making headlines, the unorthodox model is leaving many players in the healthcare industry with cold feet. "Everybody is looking at one another, saying 'I don't mind being second, but someone should go first,'" says Mr. Schwab. "This is a huge chance to take." So far, only a handful of payors and providers have made a move and a transaction has yet to involve a major hospital system, making the proposed merger between Pittsburgh-based West Penn Allegheny Health and Highmark highly significant.

Insurance companies experimented with buying hospitals in the 1990s, a trial-run Mr. Schwab calls "an unbelievable failure." For instance, Louisville-based Humana had to abandon its strategy of jointly operating healthcare plans and 76 hospitals across the country. Industry experts suggested the dual structure would likely lead to internal conflicts and weakened profits. Bond raters said it alienated physicians, who would not refer patients to Humana hospitals if they objected to certain managed-care practices. Humana ended up dividing the hospital operations into a spinoff company called Galen Health Care in 1993.

Nearly 20 years later, a national deficit and sky-rocketing healthcare costs may now play in payors' favor. Providers are already collaborating with payors through care coordination initiatives and accountable care organizations, but acquiring hospitals involves a different set of political, economic and cultural factors. "Every politician and big employer is pointing to healthcare as one of the major reasons the country is going bankrupt," says Mr. Schwab. "Insurance companies believe they can bring efficiencies to the table, and the integration of insurer and delivery system can bring a 20-30 percent reduction to the cost structure."

Keeping an eye on Pittsburgh

Five-hospital West Penn Allegheny, which is the region's second-largest chain, has faced bleak finances for the past five years and reported a $26.8 million operating loss for the first half of fiscal year 2011. Under the proposed transaction, Highmark would buy the system for nearly $500 million and assume approximately $1 billion in liabilities. Rating services are closely watching to see how the deal unfolds — Standard & Poor's quickly revised West Penn Allegheny's credit rating from negative to "developing," indicating the game-changing nature of the deal.

The proposed deal in Pittsburgh involves unique circumstances, such as Highmark's contentious relationship with West Penn's rival, University of Pittsburgh Medical Center. Disagreement over contracts led to a payor-provider standoff, with frustrated employers in the area asking the regional giants to stop bickering and playing games. UPMC finally put an end to negotiations, announcing the cancellation of Highmark contracts by the end of June 2012. After learning of Highmark's plan, UPMC announced it would not sign a new contract after the acquisition in refusal to subsidize competition.

Changes in payor-provider relationships

Unique elements of provider-payor relations combined with regional market conditions make it difficult to predict transactions on a national scale. Short of mergers or acquisitions, some hospitals may form an honest spirit of collaboration with payors through medical homes and bundled payments. Others may remain isolated.

If payors and hospitals are remote enough, though, the latter risks being considered a means to an end in their marketplace. "There are really separate worlds between payors and providers in some markets," says Bill Woodson,

senior vice president of Sg2, a healthcare intelligence and information services company based in Skokie, Ill. He names San Francisco as a city with mature physician organizations and IPAs that have been around since the 1990s. "They're sophisticated and able to manage patients and risk. The dynamics between these groups and payors are interesting. If I were a health system, I'd be worried I'd be seen as a commodity over time," says Mr. Woodson.

Payors are acting aggressively to control costs in some marketplaces, calling hospitals out for high-cost care, devising new methods to reduce spending and leaving consumers in the crossfire. In January, Blue Cross Blue Shield of Massachusetts launched its Blue Cross Hospital Choice plan, which limits the use of 15 higher-cost hospitals. Employers that sign up for the plan receive a reduced premium increase, but BCBS members face extra charges if they go to high-cost hospitals, which include prestigious organizations such as Brigham and Women's Hospital, Massachusetts General Hospital and Dana Farber Cancer Institute. "So consumers are being told, 'You can still go wherever you want, but if you go to this particular hospital, your out-of-pocket costs will be much higher,'" says Mr. Woodson. "Some consumers will be caught between brand perception, quality and marketplace power."

A game of finger-pointing

Insurers are not only holding providers more accountable, but are also beginning to tout their management skills and low-costs — a dig to hospitals and physicians. Many insurers point the finger at physicians as the culprits in rising healthcare costs, saying they order too many tests, name-brand prescriptions and implants.

Samir Qamar, MD, stands on the other end of the spectrum. In 2009, he cut insurers out of the equation when he founded MedLion, a direct primary care physician network based in Monterey, Calif. Patients pay $59 a month for discounts on primary care, such as $10 physician visits, up to 50 percent discounts on labs and imaging services and subsidized medication plans. Patients are referred to non-affiliated health insurance agents that provide plans for catastrophes. Cutting the insurer out of primary care has led to big cost-savings, according to Dr. Qamar.

"For instance, we refer to a GI physician that cuts a $2,000 colonoscopy down to $700. There are a lot of inflated costs because of insurance. If you can promise a physician you'll pay cash upfront, then physicians can give big discounts. It's estimated that up to 35-40 percent of overhead costs in a private practice come from insurance-centric systems," says Dr. Qamar. The MedLion model is friendly with hospitals, acting as a "gatekeeper" and treating patients before they become preventable hospital admissions. "We help hospitals save money by reducing uncompensated care," says Dr. Qamar. "We receive a ton of patients from hospitals."

A conundrum for consumers

Consumer reaction may be one of the most fascinating developments in payor-provider mergers, as the model is likely to create dissonance in attitudes towards quality and price. Historically, consumers have resented limitations on which physicians they can see or where they can receive an operation. "Now, they're looking at their paycheck and thinking, 'Wow, if you tell me you'll give me a break and reduce my cost for limiting my choices, I'm all in,'" says Mr. Schwab.

But, when it comes down to it, how would patients feel knowing the hospital delivering their care is owned by an insurance company? "It would scare the daylights out of me," says Mr. Schwab. "I don't think insurance companies are full of bad people who want to skimp on care, but I think the management competencies are different for what it takes to deliver care." ■

***Patient Experience: An Increasingly Critical Hospital Indicator* (continued from page 1)**

incorporated into Medicare reimbursement rates through CMS' Value Based Purchasing Program. Other drivers include growing consumerism and transparency for healthcare services and increased interest from both consumers and providers in patient-centered care.

Rising importance of patient experience

Healthcare consumers increasingly view their experience with a provider as a key consideration for determining if they'll return to or recommend the provider, largely because it remains one of the few ways consumers can differentiate providers. Over the past few decades, clinical outcomes have improved dramatically, and patients no longer view great outcomes as a key differentiator — great outcomes are expected. What remains is the patient's overall experience, which encompasses everything from customer service to patient-centeredness and care coordination among providers.

"Patients now see service as their quality, says James Merlino, MD, chief experience officer at Cleveland Clinic.

Jordan Dolin, founder of Emmi Solutions, a company that produces interactive patient educations materials with the goal of improving patient experience, concurs. "A hospital promoting excellent outcomes is like a restaurant saying we serve food…a lot of research that has been done suggest patient loyalty is based on other factors."

What is patient experience?

For hospitals to begin systematic improvement efforts of patient experience, they need to understand what "patient experience" means. A recent survey by The Beryl Institute found 73 percent of hospital executives do not have a formal definition of patient experience. Hospitals should kick off their patient experience improvement efforts by clearly defining what patient experience means to their institution. They may want to consider taking a cue from The Beryl Institute, which worked in collaboration with healthcare professionals to develop the following definition of patient experience: "The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

Despite its ambiguity, patient experience appears to be a growing concern for healthcare executives. According to an April 2011 survey by Beryl Institute, patient experience/satisfaction is one of the top three concerns of hospital executives. Other top concerns included patient safety/quality and cost reductions.

Ties to reimbursement

Part of the reason hospital executives are becoming more concerned with patient experience may be that it's finally being tied to hospital reimbursement. However, the direct impact on reimbursements is minimal. Under the Value Based Purchasing Program, which goes into effect Oct. 1, 2012, roughly one-third of one percent of reimbursements will be determined by experience scores.

Rise of consumerism

The larger impact on finances may be less direct, driven by the rise of consumerism in healthcare. "Increasingly, patients will seek out information on hospitals that provide great outcomes and great experience and will forgo facilities that fall short," says Jason A. Wolf, PhD, executive director of The Beryl Institute. "HCAHPS will continue to be a driver even with its limited, but still considerable, financial impact. The thing healthcare leaders cannot overlook is that HCAHPS combined with the increased access to web-based information have created an increasingly educated and savvy healthcare consumer."

Paul Spiegelman, founder and CEO of The Beryl Companies, adds, "There's been an explosion of consumerism. Transparency has increased; cost and quality data is more widely available because of the Internet, and we're starting to see behaviors change as a result of that information. Consumers are making smarter choices and aren't just going where their doctor tells them to go. We're starting to see parity in the industry in terms of cost and quality, and experience and service are the remaining differentiators."

The Internet also means hospital accolades — and complaints — are more powerful than ever before. While word of mouth has always been some of the most powerful marketing, Facebook, Twitter and blogs mean disgruntled and angry customers could potentially share their disappointment with thousands or more potential patients, not just those in their immediate circle.

All about culture

Hospitals that have focused on experience and service say making experience a part of the organization's culture, rather than a single program or initiative, is critical. And a culture that values experience has to be develop through the support of senior leaders.

"The process needs to be set by senior leadership. Staff members need to understand that providing great service is a critical part of what they do every day, says the Cleveland Clinic's Dr. Merlino. "Leaders need to provide clarity around why service and experience is so important — why they and their employees need to be engaged around it."

At Cleveland Clinic, building a culture around service starts with ensuring employees are engaged. In fact, the Clinic's Office of Patient Experience in collaboration with human resources is responsible for employee engagement because the institution views employees as such as im-

portant driver of patient experience. "To ultimately drive patient experience, you need motivated and engaged employees; you need to make sure they're thinking about it all of the time," says Dr. Merlino.

According to Mr. Wolf at The Beryl Institute, many hospitals fall short when they "focus" on experience by implementing tactical responses that "teach to the test" — that is they are directly related to what is being asked by the HCAHPS. For example, rounding and noise levels become key concerns, rather than an overall culture of patient-centeredness. While process improvement in the eight domains of HCAHPS can be part of a larger approach to patient experience, process improvements shouldn't be the end all be all.

Focusing on service also can't be the end all be all. "The real opportunity to have significant impact is to truly understand and strategically design the experience of care around the patient and the patient's journey. 'Good service' is about being polite, helpful and courteous, and should absolutely be expected. Those attributes are the minimum level of competence," says Kristine White, RN, BSN, MBA, vice president innovations and patient affairs at Spectrum Health System in Grand Rapids, Mich., and president of Spectrum Health Innovations. "[Our focus on patient-centeredness and experience] is not a program or initiative. It's how we do business. We talk about it in the same context as patient safety and quality and financial planning or engagement." Instead of focusing on service alone, hospitals should be concerned with access, coordination, efficiency, information, shared-decision making and compassion, says Ms. White.

But what does a culture of "patients first" look like? Most patient experience experts agree it manifests in both large and small ways. The larger, more holistic ways include developing a culture and training physicians and staff to involve patients in decision making, providing a high level of service and displaying empathy toward patients and their families.

At Spectrum Health, a culture focused on patient-experience is driven by the tenet that patients and their family are the center of the health care team — and that "family" is defined by the patient, says Ms. White. "The world of healthcare is changing very dramatically, and to not only survive but thrive in the rapidly changing consumer community, hospitals need to be able to design strategies to fully engage patients and their families in their care," she says.

Once this holistic view of patient care is developed, outstanding patient experience is manifested through smaller, simple acts that can have a big impact. For example, at the 2011 Patient Experience Summit hosted by Cleveland Clinic in May, Roberta Levy Schwartz, senior vice president of operations at The Methodist Hospital in Houston shared that Methodist's OR staff sends every surgery patient a get well card signed by every team member on the case. Ms. Schwartz said patient-experience involves both high-tech and low-tech methods and "is a daily effort [with] certainly a weekly review."

Education and information also plays an important role in a patient's experience as informed patients are more confident and tend to be more satisfied with their care, Increasingly, hospitals are using technology to transform patient education. Because patient education is largely repetitive, technological tools, such as the online patient education programs offered by Emmi Solutions, can provide interactive engaging patient education programs that are not subject to physician or clinician omissions. "A general surgeon doing hernia repairs, for example, may give the same information 30 times a day. Not only might he or she forget or be tired and leave something out, he or she also spends a lot of time doing something that can be easily automated," says Mr. Dolin.

Amenities — such as private rooms, room-service-style food service, flat screen TVs, healing gardens and complimentary/alternative service lines — are yet another area that may influence a patient's experience in a hospital. However, amenities can't be a substitute for an overall culture of patient-centeredness. "I think [amenities] are wonderful, but they don't substitute strong partnerships with and engagement of patients," says Ms. White. "I see amenities and a secondary offering but not the most important thing to patients."

Return on investment

Truly improving patient experience requires devoting designated funds toward the cause. This may include the training of employees to change the culture and the development of more specific process-improvement initiatives. However, demonstrating the return on investment for these types of improvements can be challenging. Certain elements of ROI involve tangible improvements that can be measured and assigned a dollar value. For example, better educated and empowered patients are less likely to have unanswered questions that require them to call the hospital and are less likely to be no-shows on the day of procedure. James Grant, MD, chair of the Department of Anesthesiology at Oakland University William Beaumont School of Medicine and an anesthesiologist at Beaumont Hospitals, speaking at the 2011 Patient Experience Summit, said surgical cancellation rates dropped from 4.8 percent to 1.5 percent after switching to online, interactive pre-surgical patient education. Labor savings from call volume reductions and cancelled procedures as well as revenue protected from improving the cancellation can be determined through a fairly straight-forward calculation.

The more impactful components of ROI, however, are more difficult to measure. For example, it's very difficult to say how much a certain level of improvement in HCAHPS scores will increase revenue or how much preventing a negative Tweet saved a hospital. What is certain, though, is that happier patients are more likely to return and more likely to recommend a hospital to others. They're also less likely to file a malpractice complaint, said Norm Tabler, Jr., JD, senior vice president and general counsel at Indiana University Health at the 2011 Patient Experience Summit. He called good patient experience "good business."

Beryl's Mr. Spiegelman summarizes the challenge: "[Healthcare executives] have to stop worrying so much about proving short-term ROI. Instead, they need to trust that it leads better clinical outcomes, higher patient retention, higher HCAHPS scores, fewer readmissions and better overall profitability."

Ms. White contends that outstanding patient experience is a critical component of high quality care, regardless of whether or not ROI can be proven. To her, patient experience begins by "creating an environment where patients speak up, an environment that's open and honest and where patients get the information they need and want to fully participate in their care." ■

291 Hospital and Health System Leaders to Know

2011 Hospital and Health System Leaders to Know

Becker's Hospital Review has named the following 291 individuals to its annual list, "291 Hospital and Health System Leaders to Know." These men and women help lead prominent institutions and are actively involved in American healthcare beyond the walls of their hospitals. The *Becker's Hospital Review* editorial team used several resources to develop this list, including nominations, prior *Becker's Hospital Review* lists and input from industry experts. *Note:* Individuals cannot pay for inclusion on the list. Names are presented in alphabetical order.

A full-length version of this list with full profiles on each leader is available at www.BeckersHospitalReview.com.

Richard Afable, MD. President and CEO of Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.).

Nancy Howell Agee. President and CEO of Carilion Medical Center (Roanoke, Va.).

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

Steven M. Altschuler, MD. President and CEO of Children's Hospital of Philadelphia.

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

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

Mark Baker. CEO of Jack Hughston Memorial Hospital (Columbus, Ga.).

Jeff Balser, MD, PhD. Vice Chancellor for Health Affairs and Dean of Vanderbilt University School of Medicine (Nashville, Tenn.).

Eric Barber. CEO of Northeast Regional Medical Center (Kirksville, Mo.).

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

Warren E. Beck. Senior Vice President of Finance at Vanderbilt University Medical Center (Nashville, Tenn.).

David Bernd. CEO of Sentara Health (Norfolk, Va.).

David Bixler. President and CEO of Rutherford Regional Health System (Rutherfordton, N.C.).

Michael D. Blaszyk. Executive Vice President, COO and CFO for Catholic Healthcare West (San Francisco).

David Blom. CEO of OhioHealth (Columbus).

John Bluford. CEO of Truman Medical Center (Kansas City, Mo.).

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

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

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

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

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

Richard Breon. President and CEO of Spectrum Health Hospitals (Grand Rapids, Mich.).

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

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

Craig Broman. President of St. Cloud (Minn.) Hospital.

David Bronson, MD. CEO of Cleveland Clinic Regional Hospitals (Cleveland).

Michael Browder. President and CEO of Essent Healthcare (Nashville, Tenn.).

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

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

W. Michael Bryant. President and CEO of Centra (Lynchburg, Va.).

Jim Budzinski. Acting President and CEO of WellStar Health System (Atlanta).

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

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

Michael T. Burke. Senior Vice President, Vice Dean and Corporate CFO at NYU Langone Medical Center (New York).

Mike Butler. Executive Vice President and CFO for Providence Health & Services (Renton, Wash.).

Peter W. Butler. Executive Vice President and COO of Rush University Medical Center (Chicago).

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

Vincent C. Caponi. CEO of St. Vincent Health (Indianapolis).

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

W. Larry Cash. CFO for Community Health Systems (Franklin, Tenn.).

Alan H. Channing. President and CEO of Sinai Health System (Chicago).

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

Toby Cosgrove, MD. CEO of Cleveland Clinic.

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

Brian Cramer. CEO of Orthopaedic Hospital of Wisconsin (Milwaukee).

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

Jim Dague. CEO of Goshen (Ind.) Health System.

Ralph de la Torre, MD. Chairman and CEO of Steward Health Care System (Boston).

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

Kyle DeFur. President of St. Vincent Indianapolis Hospital.

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

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

Robert A. DeMichiei. Senior Vice President and CFO of University of Pittsburgh Medical Center.

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

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

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

Victor J. Dzau, MD. President and CEO of Duke University Health System (Durham, N.C.).

Bob Edmondson. Vice President, Planning & Innovation, with West Penn Allegheny Health System (Pittsburgh).

John B. Engle. Corporate Senior Vice President and Chief Development Officer for Scripps Health (San Diego).

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

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

Sean M. Fadale. Vice President of Business Development for Nicholas H. Noyes Memorial Hospital (Dansville, N.Y.).

Robert A. Fale. President and CEO of Agnesian HealthCare (Fond du Lac, Wis.).

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

David T. Feinberg, MD. CEO of UCLA Health System (Los Angeles).

Joseph G. Felkner. CFO of Lehigh Valley Health Network (Allentown, Pa.).

Rick Ferguson. CEO of Oklahoma Surgical Hospital — Tulsa.

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

Allan Fine. Senior Vice President of Strategy and Operations. New York Eye & Ear Infirmary (New York).

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

Thomas B. Flynn, MD. Founder of the Neuro-Medical Center Clinic (Baton Rouge, La.).

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

Michael Foley, MD. CMO of Scottsdale (Ariz.) Healthcare.

David Fox. President of Advocate Good Samaritan Hospital (Downers Grove, Ill.).

Charles P. Francis. Senior Vice President and Chief Strategy Officer for Catholic Healthcare West (San Francisco).

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

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

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

Steven G. Gabbe, MD. CEO of Ohio State University Medical Center (Columbus).

Patricia Gabow, MD. CEO of Denver Health.

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

Robert Garrett. President and CEO of Hackensack (N.J.) University Medical Center.

Stephen M. Gary. CFO of Akron (Ohio) General Health System.

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

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

Steven C. Glass. CFO and Treasurer of Cleveland Clinic.

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

Joseph Golbus, MD. President of NorthShore University HealthSystem Medical Group (Evanston, Ill.).

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

Steven Goldstein. CEO Strong Memorial Hospital (Rochester, N.Y.).

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

Brett Gosney. CEO of Animas Surgical Hospital (Durango, Colo.).

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

Howard R. Grant, MD. President and CEO of Lahey Clinic (Burlington, Mass.).

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

Steven D. Grant, MD. Executive Vice President of Physician Partnerships at Detroit Medical Center.

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

Robert I. Grossman, MD. CEO of NYU Langone Medical Center (New York).

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

Charles J. Hall. National Group President of Hospital Corporation of America (Nashville, Tenn.).

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

Mark Hallett, MD. Senior Medical Director of ThedaCare (Appleton, Wis.).

Michael Halter. CEO of Hahnemann University Hospital (Philadelphia).

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

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

Gail L. Hanson. Senior Vice President and CFO of Aurora Health Care (Milwaukee).

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

Marc Harrison, MD. CEO of Cleveland Clinic Abu Dhabi.

Douglas Hawthorne. CEO of Texas Health Resources (Arlington).

C. Talbot Heppenstall, Jr. Senior Vice President and Treasurer for University of Pittsburgh Medical Center.

Dennis R. Herrick. Executive Vice President and Financial Strategy Advisor for Beaumont Health System (Royal Oak, Mich.).

Cathryn Hibbs. CEO of Deaconess Hospital (Oklahoma City).

Mairead Hickey, PhD, RN. Executive Vice President and COO of Brigham and Women's Hospital (Boston).

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

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

Bruce Holstien. President and CEO of Spartanburg (S.C.) Regional Healthcare System.

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

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

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

Michael D. Israel. President and CEO of Westchester Medical Center (Valhalla, N.Y.).

Michael S. Jellinek, MD. President of Newton-Wellesley Hospital (Newton, Mass.).

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

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

R. Milton Johnson. President and CFO of Hospital Corporation of America (Nashville, Tenn.).

Charles N. "Chip" Kahn, III. President and CEO of the Federation of American Hospitals (Washington, D.C.).

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

Phillip M. Kambic. President and CEO of Riverside Health Care (Kankakee, Ill.).

Gary Kaplan, MD. CEO of Virginia Mason Medical Center (Seattle).

Thomas Karl. President of Parkland Health Center (Farmington, Mo.).

Kenneth P. Kates. CEO of University of Iowa Hospitals and Clinics (Iowa City).

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

William A. Keaton. CEO of Baylor Medical Center at Frisco (Texas).

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

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

Harris F. Koenig. CEO of San Antonio Community Hospital (Upland, Calif.).

Alan Kopman. President and CEO of New York Westchester Square Medical Center (Bronx, N.Y.).

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

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

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

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

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

Menachem Langer, MD. CEO of Cookeville (Tenn.) Regional Medical Center.

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

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

Chuck Lauer. Former Publisher of *Modern Healthcare* (Chicago).

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

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

Luis Leon, PhD, PA-C. CEO of Alvarado Hospital (San Diego).

Mary Jo Lewis. CEO of Sumner Regional Medical Center (Gallatin, Tenn.).

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

Mike Lipomi. President and CEO of Surgical Management Professionals (Sioux Falls, S.D.).

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

Steven G. Littleson. President of Jersey Shore University Medical Center (Neptune, N.J.).

Kevin E. Lofton. President and CEO of Catholic Health Initiatives (Denver).

Susan Nordstrom Lopez. President of Advocate Illinois Masonic Medical Center (Chicago).

James V. Luck, Jr., MD. President and CEO of Los Angeles Orthopaedic Hospital.

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

John T. Malone. President and CEO of UPMC Hamot (Erie, Pa.).

James Mandell, MD. CEO of Children's Hospital in Boston.

Stephen L. Mansfield, PhD. President and CEO of Methodist Health System (Dallas).

Peter K. Markell. Treasurer of Massachusetts General Hospital (Boston).

Peter Marmerstein. CEO of CJW Medical Center (Richmond, Va.).

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

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

Patricia Maryland, DrPH. President and CEO of Providence Hospital and Medical Center (Southfield, Mich.).

Stephen R. Mason. President and CEO of BayCare Health System (Clearwater, Fla.).

Jan Mathews. Assistant Vice President of Quality Management at CaroMont Health (Gastonia, N.C.).

John McCabe, MD. CEO of University Hospital (Syracuse, N.Y.).

Peter J. McCanna. Executive Vice President of Administration and CFO of Northwestern Memorial HealthCare (Chicago).

Vince McCorkle. President and CEO of Akron (Ohio) General Health System.

Luke McGuinness. CEO of CDH-Delnor Health System (Winfield, Ill.)

Daniel Meyer. Chief Administrative Officer of Aurora BayCare Medical Center (Green Bay, Wis.).

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

Alan B. Miller. CEO of Universal Health Services (King of Prussia, Pa.).

Edward D. Miller, MD. CEO of Johns Hopkins Medicine (Baltimore).

Gary P. Miller. President and CEO of Saint Alexius Medical Center (Bismarck, N.D.).

Richard P. Miller. President and CEO of Virtua Health (Marlton, N.J.).

Thomas D. Miller. President of Division V Operations for Community Health Systems (Franklin, Tenn.).

Daniel J. Morissette. CFO of Stanford Hospital & Clinics (Stanford, Calif.).

Christopher Mowan. COO of Sunrise Hospital and Medical Center (Las Vegas).

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

Cynthia Moore-Hardy. President and CEO of Lake Health (Painesville, Ohio).

Ralph W. Muller. CEO of University of Pennsylvania Health System (Philadelphia).

Dennis M. Murphy. COO of Northwestern Memorial Healthcare (Chicago).

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

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

Harris M. Nagler, MD. President and CEO of Beth Israel Medical Center (New York).

Mark R. Neaman. President and CEO of NorthShore University HealthSystem (Evanston, Ill.).

Edwin Ness. CEO of Munson Medical Center (Traverse City, Mich.).

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

Stephen L. Newman, MD. COO of Tenet Healthcare Corporation (Franklin, Tenn.).

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

Mark Newton. President and CEO, Swedish Covenant Hospital (Chicago).

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

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

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Ken Paulus. CEO of Allina (Minneapolis).

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

William M. Peacock, III. COO for Cleveland Clinic.

Allen Peckham. Chief Development Officer of Partners Healthcare (Boston).

Judith M. Persichilli, RN. President and CEO of Catholic Health East (Newtown Square, Pa.).

Ora Hirsch Pescovitz, MD. CEO of University of Michigan Health System (Ann Arbor).

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

Bonnie Phipps. President and CEO of St. Agnes Healthcare (Baltimore).

Wright Pinson, MD. CEO of Vanderbilt Hospitals and Clinics (Nashville, Tenn.).

Kenneth S. Polonsky, MD. Executive Vice President of Medical Affairs of the University of Chicago Medical Center.

Karen Poole. Vice President and COO of the Boca Raton (Fla.) Community Hospital.

Andrea Price. CEO of Mercy Health Partners (Cincinnati).

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

Edward Prunchunas. Senior Vice President of Finance and CFO at Cedars-Sinai Medical Center (Los Angeles).

Robert W. Pryor, MD. CEO of Scott & White Healthcare (Temple, Texas).

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

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

Paul Ramsey, MD. CEO of UW Medicine (Seattle).

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

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

Stephen C. Reynolds. President and CEO of Baptist Hospital (Memphis).

Mimi Roberson. President and CEO of Presbyterian/St. Luke's Medical Center and Rocky Mountain Hospital for Children (Denver).

Jeffrey A. Romoff. President and CEO of University of Pittsburgh Medical Center.

William L. Roper, MD. CEO of UNC Health Care System (Chapel Hill, N.C.).

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

Richard K. Rothberger. Corporate Executive Vice President and CFO of Scripps Health (San Diego).

Michael T. Rowan. Executive Vice President and COO of Catholic Health Initiatives (Denver).

Amir Dan Rubin. President and CEO of Stanford Hospital & Clinics (Palo Alto, Calif.).

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

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

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

Michael Russell, MD. Orthopedic Surgeon and President of Physician Hospitals of America (Tyler, Texas).

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

Lee Sacks, MD. Executive Vice President, CMO and President of Advocate Physician Partners (Oak Brook, Ill.).

Ernie Sadau. President and CEO of CHRISTUS Health (Irving, Texas).

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

Gary Scheib. COO of University of Pennsylvania Health System (Philadelphia).

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

Kevin Schoeplein. CEO of OSF Healthcare (Peoria, Ill.).

Joseph A. Scopelliti, MD. Co-CEO of Medical Affairs, for Guthrie Health (Sayre, Pa.).

Steven Shapiro, MD. Senior Vice President and CMO of University of Pittsburgh Medical Center.

Mark Shields, MD. Vice President of Advocate Healthcare (Oakbrook, Ill.).

Douglas Silverstein. President of Glenbrook (Ill.) Hospital.

Knox Singleton. CEO of Inova Health System (Falls Church, Va.).

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

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

Daniel Slipkovich. CEO of Capella Healthcare (Brentwood, Tenn.).

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

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

Phillip Sowa. CEO of Saint Louis University Hospital (St. Louis).

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

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

James M. Staten. CFO and Senior Vice President for Finance at Yale-New Haven (Conn.) Hospital.

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

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

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

Greg Stock. CEO of Thibodaux (La.) Regional Medical Center.

David Strong. President of Rex Healthcare (Raleigh, N.C.).

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

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

Paul Summerside, MD. CMO of BayCare Clinic and AuroraBayCare Medical Center (Green Bay, Wis.).

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

Ronald W. Swinfard, MD. CEO of Lehigh Valley Health Network (Allentown, Pa.).

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

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

Craig B. Thompson, MD. President and CEO of Memorial Sloan-Kettering Cancer Center (New York City).

William P. Thompson. President and CEO of SSM Health Care (St. Louis).

Robert Thornton, Jr. President and CEO of SunLink Health Systems (Atlanta).

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

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

Karl J. Ulrich, MD. President of Marshfield (Wis.) Clinic.

Richard Umbdenstock. President and CEO of American Hospital Association (Washington, D.C.).

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

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

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

Amy Vance. COO of Presbyterian Hospital (Charlotte, N.C.).

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

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

Gary E. Weiss. CFO of NorthShore University HealthSystem (Evanston, Ill.).

Ronald J. Werthman. Vice President of Finance and Treasurer of Johns Hopkins Hospital (Baltimore).

Carl Whitmer. President and CEO of IASIS Healthcare (Franklin, Tenn.).

Anthony D. Whittemore, MD. CMO at Brigham and Women's Hospital (Boston).

Robert Wiebe, MD. Senior Vice President and CMO for Catholic Healthcare West (San Francisco).

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

Paul M. Wiles. President and CEO of Novant Health (Winston-Salem, N.C.).

Stephen A. Williams. President and CEO of Norton Healthcare (Louisville, Ky.).

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

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

Terry Woodbeck. CEO of Tulsa (Okla.) Spine and Specialty Hospital.

Tom Zenty III. CEO of University Hospitals (Cleveland). ■

60 Hospitals With Great Orthopedic Programs

60 Hospitals with Great Orthopedic Programs

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The hospitals included on this list focus on orthopedics and their orthopedic surgery departments have outstanding reputations, making them worthy of recognition. Exceptional departments often include physicians who treat professional athletes, engage in cutting-edge research and perform a large number of joint replacements every year. Many of these hospitals have been recognized for excellence in orthopedics by *US News & World Report*, HealthGrades and Thomson Reuters, and several have earned Magnet recognition. Hospitals do not pay and cannot pay for inclusion on this list. This list is not an endorsement of included hospitals or associated healthcare providers.

A full-length version of this list with full profiles on each hospital is available at www.BeckersHospitalReview.com.

Abbott Northwestern Hospital (Minneapolis).

Abington (Pa.) Memorial Hospital.

Anne Arudel Medical Center (Annapolis, Md.).

Barnes-Jewish/Washington University (St. Louis).

Beaumont Hospital (Detroit).

Brigham and Women's Hospital (Boston).

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

Cedars-Sinai Medical Center (Los Angeles).

Cleveland Clinic.

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

Good Samaritan Hospital (Los Angeles).

Hoag Orthopedic Institute (Irvine, Calif.).

Hospital for Joint Diseases—NYU Langone Medical Center (New York City).

Hospital for Special Surgery (New York City).

Hospital of the University of Pennsylvania (Philadelphia).

Indiana Orthopaedic Hospital (Indianapolis).

Ingham Regional Orthopedic Hospital (Lansing, Mich.).

John Muir Medical Center (Concord, Calif.).

Lakeview Hospital (Stillwater, Minn.).

Los Angeles Orthopaedic Hospital (Los Angeles).

Massachusetts General Hospital (Boston).

Mayo Clinic (Rochester, Minn.).

Methodist Hospital of Sacramento (Calif.).

Mount Sinai Medical Center (New York City).

Nebraska Orthopaedic Hospital (Omaha).

New England Baptist Hospital (Boston).

New York-Presbyterian University Hospital of Columbia and Cornell (New York City).

NorthShore University HealthSystem (Ill.).

Northwestern Memorial Hospital (Chicago).

Ochsner Medical Center (New Orleans).

Orthopaedic Hospital of Wisconsin (Glendale).

Orthopedic Hospital of Lutheran Healthcare Network (Fort Wayne, Ind.).

Overland Park Regional Medical Center (Kan.).

Paris Regional Medical Center (Texas).

Parkview Orthopedic Hospital (Fort Wayne, Ind.).

Presbyterian Orthopaedic Hospital (Charlotte, N.C.).

Riverside Medical Center (Kankakee, Ill.).

Ronald Reagan UCLA Medical Center (Los Angeles).

Rowan Regional Medical Center (Salisbury, N.C.).

Rush University Medical Center (Chicago).

Salem (Ore.) Hospital.

Santa Monica (Calif.)-UCLA Medical Center and Orthopedic Hospital.

Scripps Green Hospital (La Jolla, Calif.).

South Nassau Communities Hospital (Oceanside, N.Y.).

St. Anthony's Memorial Hospital (Effingham, Ill.).

St. Helena Hospital (Napa Valley, Calif.).

St. Joseph Hospital (Orange, Calif.).

Stanford University Hospitals & Clinics (Palo Alto, Calif.).

Tampa (Fla.) General Hospital.

Texas Orthopedic Hospital (Houston).

Thomas Jefferson Hospital (Philadelphia).

Tulsa (Okla.) Spine & Specialty Hospital.

University Hospitals Case Medical Center (Cleveland).

University of Iowa Hospitals & Clinics (Iowa City).

University of Pittsburgh Medical Center.

University of Washington Medical Center (Seattle).

UPMC Hamot (Erie, Pa.).

USC University Hospital (Los Angeles).

Valley Medical Center (Renton, Wa.). ■

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A CEO Walks Into a Patient Room: Q&A With Dr. David Feinberg, CEO of UCLA Health System

Molly Gamble

David T. Feinberg, MD, is the CEO of UCLA Hospital System, associate vice chancellor of UCLA Health Sciences and the first person to tell you 99th percentile isn't good enough.

A psychiatrist and former medical director of UCLA's Resnick Neuropsychiatric Hospital, Dr. Feinberg assumed his post as CEO in 2007. Patient satisfaction scores have increased from the 38th to 99th percentile at UCLA since then, due in part to his intent focus on the patient experience. He distributes his cell phone number to patients and employees, welcoming their calls all hours of the day. He doesn't believe in red tape or bureaucracy, but firmly believes in miracles. Here, Dr. Feinberg shares his leadership philosophy and explains why he won't be content until every UCLA patient is completely satisfied.

Q: A *Los Angeles Times* article from May 13 mentioned you pass out your business card to patients and encourage them to call your cell phone. How do you maintain this level of accessibility?

Dr. David Feinberg: I started visiting with patients when I ran the psychiatric hospital here. Many of the patients were suicidal or homicidal, most didn't want to be admitted, but they would still hug us and thank us at discharge. It was an old building in poor condition, but we seemed to provide a level of care that went beyond the structure. When I got this job, I went into patient rooms because I was really scared. There was a lot about running a large academic medical center that I didn't know. I spent time with patients to decrease my anxiety — it was something I knew how to do.

After three months, I learned two things. One: UCLA performs miracles. We perform more organ transplants than any other hospital in the country. We invented PET scans. We diagnosed the first case of AIDS. I learned about all of these great accomplishments, but I also learned that people wouldn't refer us to a friend. We ranked in the 38th percentile for how many patients would refer us to family or friends. That was because they didn't know who their physician was, no one made eye contact, the place was dirty, the air conditioning didn't work, hot food wasn't hot and TVs didn't work.

I figured I could never be as smart as UCLA's miracle workers but I could make this a more compassionate place. Now I visit patients because it's the most fun part of the job. I love talking to families, and our patient satisfaction has gone to the 99th percentile. When I'm in a room and staff members come in, it's a totally different experience. Everybody is giving business cards and writing cell phone numbers down — not just me.

Q: Can you recall a memorable experience you've had with a patient?

Dr. Feinberg: I met a grandmother last week who was dying of metastasized breast cancer. Her daughter was having a baby in northern California, and she wasn't going to be able to see the baby. Our nurses heard about it and had the daughter transferred here. The mother was induced, the grandson was born and the nurses gave him to the grandmother to hold.

Just last night, I received an email from a urologist, telling me about this incredible moment. He was explaining something to a Spanish-speaking patient, and his Spanish was broken. So the nurse sees this interaction. She leaves the room and comes back with a laptop with [Skype] and connects the urologist with a Spanish-speaking translator. The urologist said, "The nurse saw I wasn't doing a good job and she immediately fixed it, without even saying anything."

Q: UCLA Health recently joined the National High-Value Healthcare Collaborative. Do you think healthcare is shifting from a philosophy of competition to collaboration?

Dr. Feinberg: We've always been collaborative. We're a relatively new player in healthcare. We were singled out by Dartmouth Clinic for the cost of care for Medicare patients who died here versus those who died at Mayo Clinic. It was something like $96,000 versus $45,000. We said we'd like to learn more about it. Really, though, materials published have shown that variance is much less if you make certain adjustments, such as socioeconomic class and the severity of the condition.

Still, I think we waste tons of money every day. The work Dartmouth is doing is exactly what we want to be a part of: sharing data, sharing best practices and this whole goal of improving value through higher quality and less cost. Yes, we want to be a part of that. We were knocking on the door, asking to be a part of that. We believe healthcare is shifting from volume- to value-based. We have a lot of expertise, but we also have a lot to learn. We might have the best organ transplant survival rate, but there's room for improvement with our end of life care. These collaborations allow us to share what we know and learn from others.

Q: What has been one of your proudest moments at UCLA thus far? When was a moment you left the office and felt good about something you accomplished that day?

Dr. Feinberg: I'm a psychiatrist, and I always had this fear that I wouldn't be therapeutic for a rape victim. And I remember seeing my first rape victim — she was in her young 20s, worked as a waitress. She experienced this terrible rape scene. I don't know why it was my worst fear to counsel her, maybe because [rape is] so brutal.

We have a great rape treatment program here, and I referred her to our program. I received a long thank-you note from her about how kind I was and how well her treatment was going, and I thought, 'Good job Dave, you did it.' For some reason, that's something that's always scared me. It was, I think, a traumatic event that personally made me feel like a healer.

Q: You're known for outstanding communication with patients, but how do you maintain employee engagement? Do you make yourself as accessible to them as you do patients?

Dr. Feinberg: I don't differentiate. Employees have my cell phone number. I tell them to call me any hour of the day. If they have any problems, I tell them to email me, call me, page me — I'm here. Please get in touch with me. If something isn't going right at work and we can fix it, I want to know right away. I want to do my best to get the bureaucracy out of the way.

Q: You've also said you want patients to be treated like members of your own family. What other philosophies, events or people influence your leadership style?

Dr. Feinberg: I had great mentors. One of them is a gentleman named William Simon Jr. He said to me, when I got this job, "You're going to have thousands of decisions coming at you every day. You need to focus on one or two things and that's all you can really change." So this idea of singular focus has stayed with me. I chose to focus on improving our connection in a human level with our patients. My family is also really supportive. My parents are really good with people, and my wife is a great partner.

Q: UCLA has made major strides in the last few years, particularly in patient satisfaction scores. How do you recommend hospital executives/managers handle negative feedback? How do you approach criticism?

Dr. Feinberg: Well, I'm the most critical of all — 99th percentile patient satisfaction sucks. That puts us in 99th percentile among hospitals, so 85 out of 100 patients would recommend us to family or friends. All that means to me is that we have failed miserably with 15 patients and families. And I wanted those patients treated like my family. I'm critical of myself every day. We can't ever mess up. We need 100 out of 100 patients to be satisfied and it has to stay that way. This 99th percentile is terrible, but it's much better than where we started.

I'm critical of myself, and I don't care about the other stuff. That's a distraction. Talk about whether I'm overpaid or underpaid — that comes with the territory. I just hope I leave this place better than I found it. We have more applications to UCLA's undergrad program than any other university in the country. A third of our undergrads are the first in their family to go to college. We're owned by the people of California. I'm so proud to be part of this place.

Q: With illness and disease, hospitals aren't always the most optimistic work environments. How do you keep morale high among employees?

Dr. Feinberg: Our morale is really high. Employee satisfaction is high. Even if we're faced with difficult cases that don't go well, or people don't recover, I think it's important for us to be kind and alleviate suffering. If we can do those two things, we're living up to our mission.

Our true north is serving others, making our patients more comfortable. It might seem tough but it's very inspiring, even when it means you're crying with the family. Personally, every day when I'm walking into work I think three words: passion, humility and integrity. If I can get those three right, I'm doing my job.

Q: Healthcare reform has spurred change left and right, and it can be difficult to keep up with deadlines, new programs and developments. With your busy schedule, how do you remain informed on the politics, legislation and other issues affecting healthcare delivery?

Dr. Feinberg: I don't think that's my job. I think my job is to take care of the patient right in front of us. The next patient is a donor, voter and citizen. If they believe UCLA is here to serve them, they won't let anything bad happen to us. We see 1.5 million patients per year. That's our answer to healthcare reform. That focus [on patients] is crucial. ■

25 Largest Non-Profit Hospitals in America

Here are the 25 largest non-profit hospitals in the United States, listed by number of beds.

Note: The hospital bed counts reported here include all medical/surgical and special care beds as reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include bed counts from other facilities that share a provider number with the main hospital. The American Hospital Directory was used as a source to verify various part of the following text.

1. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City) — 2,272 beds

2. Florida Hospital (Orlando) — 2,001 beds

3. University of Pittsburgh Medical Center-Presbyterian — 1,601 beds

4. Indiana University Health Methodist Hospital (Indianapolis) — 1,510 beds

5. Baptist Medical Center (San Antonio) — 1,443 beds

6. Montefiore Medical Center-Moses Division Hospital (Bronx, N.Y.) — 1,427 beds

7. Orlando (Fla.) Regional Medical Center — 1,401 beds

8. Methodist University Hospital (Memphis, Tenn.) — 1,273 beds

9. The Cleveland Clinic — 1,270 beds

10. Barnes-Jewish Hospital (St. Louis) — 1,258 beds

11. Buffalo (N.Y.) General Hospital — 1,241 beds

12. Norton Hospital (Louisville, Ky.) — 1,238 beds

13. The Mount Sinai Medical Center (New York City) — 1,223 beds

14. Christiana Hospital (Newark, Del.) — 1,075 beds

15. Beaumont Hospital-Royal Oak (Mich.) — 1,061 beds

16. North Shore University Hospital (Manhasset, N.Y.) — 1,029 beds

17. Albert Einstein Medical Center (Philadelphia) — 1,012 beds

18. Jewish Hospital (Louisville, Ky.) — 1,012 beds

19. Beth Israel Medical Center-Petrie Division (New York City) — 988 beds

20. Spectrum Health Butterworth Hospital (Grand Rapids, Mich.) — 978 beds

21. Aurora Saint Luke's Medical Center (Milwaukee) — 973 beds

22. The Brookdale University Hospital and Medical Center (Brooklyn, N.Y.) — 955 beds

23. Cedars-Sinai Medical Center (Los Angeles) — 955 beds

24. The Moses H. Cone Memorial Hospital (Greensboro, N.C.) — 930 beds

25. Saint John's Mercy Medical Center (St. Louis) — 919 beds ■

25 Largest For-Profit Hospitals in America

Here are the 25 largest for-profit hospitals in the United States, listed by number of beds.

Note: The hospital bed counts reported here include all medical/surgical and special care beds as reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include bed counts from other facilities that share a provider number with the main hospital. The American Hospital Directory was used as a source to verify various part of the following text.

1. Methodist Hospital (San Antonio) — 1,406 beds

2. Edinburg (Texas) Regional Medical Center — 816 beds

3. Henrico Doctors' Hospital-Forest Campus (Richmond, Va.) — 808 beds

4. North Shore Medical Center (Miami) — 778 beds

5. CJW Medical Center-Chippenham Campus (Richmond, Va.) — 731 beds

7. Medical City Hospital (Dallas) — 645 beds

8. Sunrise Hospital and Medical Center (Las Vegas) — 638 beds

9. Brookwood Medical Center (Birmingham, Ala.) — 602 beds

10. Oklahoma University Medical Center (Oklahoma City) — 591 beds

11. Las Palmas Medical Center (El Paso, Texas) — 587 beds

12. Centennial Medical Center (Nashville, Tenn.) — 580 beds

13. McAllen (Texas) Medical Center — 572 beds

14. Hillcrest Medical Center (Tulsa, Okla.) — 535 beds

15. West Florida Hospital (Pensacola, Fla.) — 531 beds

16. Doctors Hospital at Renaissance (Edinburg, Texas) — 530 beds

17. Saint Francis Hospital (Memphis, Tenn.) — 528 beds

18. Wesley Medical Center (Wichita, Kan.) — 511 beds

19. Providence Memorial Hospital (El Paso, Texas) — 508 beds

20. Hahnemann University Hospital (Philadelphia) — 492 beds

22. Delray Medical Center (Delray Beach, Fla.) — 465 beds

23. Saint Mary's Medical Center (West Palm Beach, Fla.) — 463 beds

24. JFK Medical Center (Atlantis, Fla.) — 448 beds

25. Doctors Medical Center of Modesto (Calif.) — 445 beds ■

25 Top Grossing Non-Profit Hospitals in America

Here are the 25 top grossing non-profit hospitals in the United States listed by gross revenue, according to CMS cost report data analyzed by American Hospital Directory.

Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.

1. University of Pittsburgh Medical Center Presbyterian — $10.19 billion
2. The Cleveland Clinic — $9.14 billion
3. Cedars-Sinai Medical Center (Los Angeles) — $7.99 billion
4. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City) — $7.52 billion
5. Florida Hospital Orlando — $7.12 billion
6. Stanford (Calif.) Hospital — $6.71 billion
7. Montefiore Medical Center-Moses Division Hospital (Bronx, N.Y.) — $6.19 billion
8. Hospital of the University of Pennsylvania (Philadelphia) — $5.98 billion
9. Temple University Hospital (Philadelphia) — $5.9 billion
10. Orlando (Fla.) Regional Medical Center — $5.71 billion
11. Massachusetts General Hospital (Boston) — $5.64 billion
12. Crozer-Chester Medical Center (Upland, Pa.) — $4.81 billion
13. Hackensack (N.J.) University Medical Center — $4.72 billion
14. Brigham and Women's Hospital (Boston) — $4.58 billion
15. Vanderbilt University Medical Center (Nashville, Tenn.) — $4.52 billion
16. Indiana University Health Methodist Hospital (Indianapolis) — $4.19 billion
17. Tampa (Fla.) General Hospital — $4.16 billion
18. Northwestern Memorial Hospital (Chicago) — $4.15 billion
19. Thomas Jefferson University Hospital (Philadelphia) — $4.12 billion
20. The Methodist Hospital (Houston) — $4 billion
21. Duke University Hospital (Durham, N.C.) — $3.92 billion
22. Yale-New Haven (Conn.) Hospital — $3.9 billion
23. North Shore University Hospital (Manhasset, N.Y.) — $3.84 billion
24. Norton Hospital (Louisville, Ky.) — $3.77 billion
25. Loma Linda (Calif.) University Medical Center — $3.69 billion ■

25 Top Grossing For-Profit Hospitals in America

Here are the 25 top grossing for-profit hospitals in the United States listed by gross revenue, according to CMS cost report data analyzed by American Hospital Directory.

Note: The hospital total patient revenues reported here are reported to CMS by the hospitals in their most recent cost reports and, in some cases, may include patient revenue from other facilities that share a provider number with the main hospital.

1. Methodist Hospital (San Antonio) — $4.22 billion
2. Hahnemann University Hospital (Philadelphia) — $3.06 billion
3. Doctors Medical Center of Modesto (Calif.) — $2.68 billion
4. Brookwood Medical Center (Birmingham, Ala.) — $2.67 billion
5. CJW Medical Center-Chippenham Campus (Richmond, Va.) — $2.6 billion
6. Sunrise Hospital & Medical Center (Las Vegas) — $2.47 billion
7. Medical City Hospital (Dallas) — $2.38 billion
8. Las Palmas Medical Center (El Paso, Texas) — $2.3 billion
9. JFK Medical Center (Atlantis, Fla.) — $2.24 billion
10. Oklahoma University Medical Center (Oklahoma City) — $2.05 billion
11. Good Samaritan Hospital (San Jose, Calif.) — $2.04 billion
12. Henrico Doctors' Hospital-Forest Campus (Richmond, Va.) — $1.98 billion
13. North Florida Regional Medical Center (Gainesville, Fla.) — $1.93 billion
14. Memorial Hospital (Jacksonville, Fla.) — $1.89 billion
15. Riverside (Calif.) Community Hospital — $1.77 billion
16. Centennial Medical Center (Nashville, Tenn.) — $1.74 billion
17. Brandon (Fla.) Regional Hospital — $1.69 billion
18. Regional Medical Center of San Jose (Calif.) — $1.68 billion
19. Wesley Medical Center (Wichita, Kan.) — $1.63 billion
20. Clear Lake Regional Medical Center (Webster, Texas) — $1.59 billion
21. Edinburg (Texas) Regional Medical Center — $1.58 billion
22. Providence Memorial Hospital (El Paso, Texas) — $1.57 billion
23. North Shore Medical Center (Miami) — $1.55 billion
24. Doctors Hospital at Renaissance (Edinburg, Texas) — $1.52 billion
25. Fountain Valley (Calif.) Regional Hospital and Medical Center — $1.49 billion ■

15 Largest Non-Profit Hospital Systems

Here are 15 of the largest non-profit hospital systems in the country, based on number of hospitals.

Catholic Health Initiatives (Denver) — 72 hospitals

Ascension Health (St. Louis) — 69 hospitals

Catholic Healthcare West (San Francisco) — 41 hospitals

Kaiser Permanente (Oakland, Calif.) — 35 hospitals

Catholic Health East (Newton Square, Pa.) — 33 hospitals

Sanford Health & MeritCare (Sioux Falls, S.D., and Fargo, N.D.) — 31 hospitals

Carolinas Healthcare System (Charlotte, N.C.) — 29 hospitals

Avera Health (Sioux Falls, S.D.) — 28 hospitals

Sisters of Mercy Health System (Chesterfield, Mo.) — 28 hospitals

CHRISTUS Health (Irving, Texas) — 27 hospitals*

Providence Health & Services (Portland, Ore.) — 27 hospitals

Baylor Health Care System (Waco, Texas) — 26 hospitals

Iowa Health Systems (Des Moines) — 25 hospitals

Sutter Health (Sacramento, Calif.) — 24 hospitals

Intermountain Healthcare (Salt Lake City) — 23 hospitals ■

*Denotes number of hospitals in the United States. CHRISTUS Health also operates facilities in Mexico.

15 Largest For-Profit Hospital Systems

Here are 15 of the largest for-profit hospital operators in the country by number of hospitals.

1. Hospital Corporation of America (Nashville, Tenn.).
Number of hospitals: 164
CEO: Richard Bracken
2010 revenue: $30.683 billion

2. Community Health Systems (Brentwood, Tenn.).
Number of hospitals: 133
CEO: Wayne Smith
2010 revenue: $12.986 billion

3. Health Management Associates (Naples, Fla.).
Number of hospitals: 59 (to be 66 when completing Mercy transaction in October)
CEO: Gary D. Newsome
2010 revenue: $5.115 billion

4. LifePoint Hospitals (Brentwood, Tenn.).
Number of hospitals: 50
CEO: William F. Carpenter III
2010 revenue: $3.26 billion

5. Tenet Healthcare Corp. (Dallas).
Number of hospitals: 49 (acute care)
CEO: Trevor Fetter
2010 revenue: $9.205 billion

6. Vanguard Health System (Nashville, Tenn.).
Number of hospitals: 26
CEO: Charles N. Martin, Jr.
2010 revenue: $3.377 billion

7. Universal Health Services (King of Prussia, Pa.).
Number of hospitals: 22 (acute care)
CEO: Alan B. Miller
2010 revenue: $5.57 billion

8. IASIS Healthcare (Franklin, Tenn.).
Number of hospitals: 19
CEO: W. Carl Whitmer
2010 revenue: $2.5 billion

9. National Surgical Hospitals (Chicago).
Number of hospitals: 17
CEO: John G. Rex-Waller
2010 revenue: Not available

10. Capella Healthcare (Brentwood, Tenn.).
Number of hospitals: 15
CEO: Daniel S. Slipkovich
2010 revenue: Not available

11. Prime Healthcare Services (Inglewood, Calif.).
Number of hospitals: 14 (acute care)
CEO: Lex Reddy
2010 revenue: Not available

12. Ardent Health Services (Nashville, Tenn.)
Number of hospitals: 7 (acute care)
CEO: David T. Vandewater
2010 revenue: Not available

13. SunLink Health Systems (Atlanta).
Number of hospitals: 7
CEO: Robert M. Thornton, Jr.
2010 revenue: $197.8 million

14. Steward Health Care System (Boston)
Number of hospitals: 6
CEO: Ralph de la Torre, MD
2010 revenue: Not available

15. Foundation Surgical Hospital Affiliates (Oklahoma City).
Number of hospitals: 4
CEO: Thomas A. Michaud
2010 revenue: Not available ■

Kurt Salmon

A New Approach to Ambulatory Services

By Kate Lovrien, Senior Strategy Manager, Kurt Salmon, Luke Peterson, National Director, Health Care Strategy Practice, Kurt Salmon, Brandon Robertson, Administrative Resident, Centura Health, and Mackenzie Santana, Executive Assistant, Centura Health

In response to an increased emphasis on quality and effectiveness of care, hospitals and health systems must refocus their efforts on the broader care continuum, defined as healthcare outside the traditional hospital walls. No longer can community hospitals consider ambulatory services as separate from their core service and mission. While the ability to "own" the entire ambulatory continuum is not realistic for most community hospitals and systems, hospitals should take a leadership role in organizing the ambulatory continuum to benefit their communities.

Over the past two decades, the community hospital strategy for ambulatory care has generally been bifurcated: either a joint venture with physicians, while trying to build or maintain volumes or competing with physician-invested ambulatory services, often losing volumes rapidly. Strategy was driven by revenue, profits and efficiency.

Today, hospitals and health system must change their way of thinking about ambulatory services from a profit center and physician economic alignment tool to a targeted care delivery channel that must be organized and coordinated with the other elements of the continuum.

As a result, ambulatory services must be:

- Highly efficient (focused factories)
- At locations convenient for the patient (access points within communities rather than on hospital campuses)
- Integrated into the entire continuum of care rather than a carve-out to capture higher profitability
- Aligned with physicians in areas beyond economics (integrated systems of care)

To address these needs, we propose hospitals and health systems develop ambulatory assets using a framework with five levels of care. This framework provides a clear model for organizing future ambulatory services to best serve the patients in their specific communities.

Five levels of ambulatory care

Groupings of ambulatory services and their supporting asset infrastructure must be organized to effectively support the delivery of integrated systems of care across the ambulatory continuum. To this end, successful community hospitals and systems create a logical cadre of ambulatory services and infrastructure in their markets.

Our research suggests that ambulatory services can be organized into five defined groupings. These groupings provide a logical basis for community hospitals and systems to organize the ambulatory continuum in their communities.

Level 1: Virtual health

Virtual healthcare is defined as education and care provided through the use of email, websites, electronic physician visits, telemedicine and other electronic sources. As patients become more concerned with the value of healthcare, these avenues of physician-patient communication are likely to become much more relevant in daily operations. The American Medical Association has reported that as many as 70 percent of all doctor visits are for information only or for matters that can be easily handled over the phone.[1] Virtual health can be further segmented into three areas:

Email: Today, most health plans are piloting programs to pay physicians for online patient consultations. Many physicians are discovering that email is a more efficient manner for scheduling appointments, refilling prescriptions and transmitting standard lab results. By creating a convenient avenue of

Five Levels of Ambulatory Care

	AMBULATORY LEVEL	SUMMARY DESCRIPTION
Typically System-wide	LEVEL 1: Virtual Health	> Virtual access and educational strategies focused on providing information and resources to prevent disease and manage chronic illnesses. Lack of face-to-face interaction is the hallmark of assets supporting this ambulatory level.
	LEVEL 2: Mobile Health	> Remote and mobile strategies focused on providing preventative, screening and diagnostic capabilities close to the communities that cannot support or do not have access to specialty care locally. The hallmark of assets supporting this level includes significant use of information systems and mobile infrastructure.
Local (fixed assets)	LEVEL 3: Primary Diagnosis and Treatment	> Mix of primary care services and the supporting diagnostics needed to care for the local populations in a permanent location. The asset base for this level will be primary care offices, imaging, and potentially after-hours care and urgent care, perhaps in conjunction with retail.
	LEVEL 4: Specialty Diagnosis and Treatment	> Multispecialty services for one or more disease states and focused on diagnostic and treatment services that can be done safely outside a hospital environment. The asset base will be focused on specialty diagnostic and treatment services and the supporting medical office space for aligned physicians.
	LEVEL 5: Destination Ambulatory	> A full range of multispecialty services for multiple disease states, focused on providing all services except those requiring hospital admissions. The asset base will require a sophisticated diagnostic and treatment facility and supporting medical office spaces for aligned multispecialty, single specialty and primary care physicians.

Level I: Virtual Health Example

Zipnosis: Online Medical Service

Zipnosis provides an online, innovative approach to healthcare for their target market of young adults, ages 18-35, who often are not insured, don't get sick often and are looking for ways to save money.

Patients fill out an online survey, which is then reviewed by a nurse practitioner who provides a diagnosis and, if needed, the necessary prescription. This service is not recommended for patients who are experiencing a severe medical condition.

communication, physicians are noticing a reduced number of phone calls and pages, allowing for better workflow control.

Telemedicine: Telemedicine has also become an integral piece to providing healthcare to rural communities, patients with chronic conditions and patients who may not be able to easily travel to meet face-to-face with a physician. However, because telemedicine can cross state lines, some states could require a state license for out-of-state physicians whose use of telemedicine crosses into their jurisdiction, even if the physician's practice is physically located elsewhere.[2]

Call centers: Historically a triage function or information source, progressive hospitals and systems are increasingly using call centers to deliver care. Types of call centers might include RN triage, ED transfers, physician and facility referrals, appointment scheduling, class scheduling and patient callbacks for chronic heart failure, post partum moms, diabetics, ED patients who left without being seen, etc.

These services are considered a unique level of ambulatory access due to the ambiguity around privacy and confidentiality, reimbursement and standards of care that should apply. As healthcare reform continues to evolve, many regulatory questions are likely to be further defined and answered.

Level 2: Mobile health

Mobile healthcare services include remote and mobile strategies aimed at providing preventive, diagnostic and screening capabilities close to communities that do not have access to care locally. The hallmark of these services is the usage of mobile infrastructure, information technology and sometimes, rotating physicians and technical staff.

Because populations in many rural markets cannot support dedicated availability of comprehensive healthcare services and attracting physicians to live and work in many rural markets proves challenging, these services are critical to providing access to care in rural settings. Moreover, Level 2 services are acutely needed by rural populations — by many measures, rural residents are less healthy than their urban counterparts. Level 2 services are primarily influenced by three factors:

Geographic focus: Historically, hospitals and systems have thought they needed a large, sparsely populated geography to most effectively take advantage of a Level 2 ambulatory model. However, underserved segments of an urban market often have many similarities: lack of resources, poor payor mix and a need for screening and chronic care management.

Service offerings: Lack of care availability results in patients often forgoing preventative care or specialty diagnostics until disease is advanced. To control costs, early diagnosis is critically important. As such, the logical focus areas for Level 2 services are the leading causes of death: heart disease, cancer and stroke. The high incidence and costs of these diseases make them ideal candidates for remote diagnostic and screening services. Early diagnosis of diseases or risk factors for heart disease, cancer and stroke are key components of hospitals and systems moving "upstream" to manage populations earlier in their disease process.

Lack of physicians: In markets that are candidates for Level 2 models, lack of services goes hand-in-hand with lack of physicians to provide those services. As such, any mobile health model must consider the way in which provider need will be addressed. Mobile services provided by non-physician providers are becoming increasingly common in most markets. This is historically true for imaging dianostics, but increasingly so for other types of diagnostic and treatment services. The most rural areas continue to test and consider models that allow highly trained and remotely monitored non-physician providers to deliver additional care.

As hospitals and systems develop Level 2 services, it is beneficial to develop a portfolio of remote services for high-incidence, high-cost diseases. Since few, if any, hospital systems in most markets have aggregated such a portfolio of services, there is likely a first mover advantage to solidifying markets.

Level 2: Mobile Health Examples

Cancer services

- **Mobile digital mammography and breast biopsy services**
- **Virtual colonoscopy with remote reading and mobile colonoscopy services**
- **Education and consultation: Condition education, risk factors, screening types, prevention**
- **Treatment planning: Coordination with cancer system of care (if developed)**
- **Rotating employed or affiliated specialists to rural access points for consults.**

Level 3: Primary care

The Level 3 ambulatory model is a composition of primary care services and supporting diagnostics needed to care for local populations at a permanent location. For hospitals and systems to be effective in population and patient health management, Level 3 ambulatory models must be aligned and developed throughout the organization's markets. The competitive advantage for this model of access point is the optimization of value for patients and employers, achieved by providing high-quality care and excellent service in a convenient location and at a reduced cost.

The key challenge in this model is to provide the correct range of service options without expanding the menu of services to a level that adds complexity or lacks financial viability. The best mix of services can be determined by separating the Level 3 ambulatory model into its three major components based on who determines the need for care: patients, employers or physicians.

Patient-directed care: In patient-directed care, the patient has identified that he or she needs medical care immediately, but the degree of care has not yet reached emergent levels. These criteria set Level 3 care apart from the other levels of care because they suggest that patients will be drawn to their perceived highest-value location for care when their primary care physician is unavailable or they have not cultivated that relationship. The most common patient-directed care models include urgent care facilities, retail clinics and primary care offices with extended or walk-in hours.

Urgent care: Urgent care is characterized as the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Both retail clinics and physician offices with extended hours are types of urgent care locations, providing better access in a lower cost environment.

Level 3: Patient-Directed Care Example

Southern Urgent Care has 19 locations, 50 percent in occupational medicine and 50 percent in urgent care. These entities are run like urgent care entities, which has its own implications:

- **They operate seven days a week, but hours of operation vary by clinic**
- **Always staffed with a physician in urgent care and a mid-level staff person in occupational medicine.**
- **Accept select forms of payment**

These clinics have performed well over the past 25 years, with an annual EBITDA of 19 percent and net income of 15 percent.

Employer-directed care: This relationship is generated through the legal requirement that employers have worker's compensation insurance. As in patient-directed care, value needs to be optimized, which centers on the employer's need to minimize absences due to health or injury and ensure employees are ready to return to work after an injury.

Level 4: Single-specialty diagnostic and treatment

Level 4 ambulatory models move beyond basic primary care to focus on a single disease state with specialty physicians, diagnostic and treatment elements. These are specialty "focused factories" and provide access to the full suite of services traditionally found only on hospital campuses. Sometimes, Level 4 services are co-located with primary care diagnostic and consultative services. Often, these centers also offer access to non-clinical services related to their specific disease state (such as social work and counseling services).

Over the past decade, many Level 4 ambulatory models have sprung up as a result of technology and regulatory and reimbursement trends, allowing physicians to invest in providing highly reimbursed technologies and thereby support their professional fee incomes. As such, Level 4 models have historically been seen as competitive to a hospital's mission. However, the trends towards physician ownership of diagnostic and treatment services in a Level 4 setting is becoming so entrenched that many hospitals have sought to joint venture Level 4 projects with physicians as way of aligning the economics of hospitals and physicians.

While economic considerations are critical to the discussion of Level 4 models, the following patient care benefits should also be considered.

Convenience. By providing single-site, off-campus access to a comprehensive array of services, this model eliminates travel and scheduling burdens placed on patients by traveling to multiple sites for outpatient services and eliminates the burdens associated with navigating large, complex inpatient facilities for ambulatory care.

Efficiency. Focus on a single disease state allows operations (such as staffing models, care protocols and service standards) to be tailored to the behaviors of a relatively uniform patient population. As a result, such centers

Level 4: Single-Specialty Diagnostic Example

The Mountain Cancer Centers (MCCs) provide an example of Level 4 services. The multi-specialty group consists of 70 physicians in the Mountain market that offer services at 20 sites.

While some of sites are essentially physician offices, offering consultative services only, the group has several centers that offer single site access to a wide array of co-located outpatient cancer. The more comprehensive centers not only offer clinical care, but also participate in clinical research and offer onsite access to social workers.

Essentially, MCCs' distributed network of Level 4 centers allows many Colorado residents to access comprehensive cancer care close to home, without navigating cumbersome inpatient facilities. Moreover, co-location of physicians and common practice infrastructure enables a multidisciplinary approach to diagnosis, planning and treatment.

can reduce costs via high resource utilization and eliminate patients' non-value-added time during care (e.g. wait-time).

Expertise. Focus on a single disease state also enables sub-specialization of physicians, nurses, mid-level providers and technicians, which can increase the clinical quality of care provided.

The most successful Level 4 models have a combination of higher reimbursed services and a focused patient population with common needs or services for which care is primarily provided on an ambulatory basis. Population-centered models most often serve women or children. Service-centered models often focus on orthopedics, GI and digestive diseases, eye, dermatology and plastics and cancer.

Level 5: Destination ambulatory centers

Level 5 ambulatory models combine a broad range of specialties in typically a multi-disciplinary or quasi-multidisciplinary fashion. The model benefits from a critical mass of services and physician specialties such that the location of these centers becomes a "destination" for healthcare, similar to hospitals. As such, the infrastructure to support a Level 5 ambulatory model typically resembles a community hospital without beds.

Historically, in a hospital-centric paradigm, the Level 5 ambulatory model was used as a starting point for developing a new hospital in typically a growing suburban market. However, with the shift to outpatient care and the demand for more efficient methods of delivering ambulatory care, the Level 5 ambulatory model is being viewed as an end point.

The benefits of specialty services being grouped into a Level 5 model are fivefold:

Accessibility: The lack of inpatient beds and the supporting infrastructure required by a hospital allows even very large Level 5 settings to be more accessible to patients than a hospital. This accessibility comes from locating the centers in new growth areas where hospitals have not been developed, and from the simplicity of allowing easier navigation through the campus and the building.

Full range of services: Physicians and patients benefit from a single "one stop" location with a full range of services. Convenience is often enhanced by open scheduling practices for diagnostics on the campus, allowing patients seeing on-site physicians to schedule and complete needed diagnostic testing in one location.

Multi-specialty: The multi-specialty nature of the location is a requirement for effective rapid cross-referrals in a multi-specialty group. Even in the private practice environment, the ability to cross-refer patients increases through the proximity of independent groups (similar to a private practice hospital medical staff). Moreover, most Level 5 settings have developed the reception, registration and information system infrastructure to replicate multi-specialty group information flows.

Destination Ambulatory Center Examples

Midwestern System has several ambulatory destination centers.

SERVICES	SITE 1	SITE 2
Physician Model	> Employed physician group	> Independent physicians
Primary Care Physicians	> 20 FTE > Several physicians in off-site Level 3 Models supporting	> 12 FTE > Several physicians in two off-site Level 3 Models supporting
Specialty Care Physicians	> 40 FTE	> 10 FTE
Emergency Room	> 65,000 visits > 5.5% admission rate > 26 treatment bays > 6 short-stay beds	> 20,000 visits > 3% admission rate > 15 treatment bays > 6 short-stay beds
Diagnostics	> Full range of non-invasive imaging and specialty diagnostics > Mobile PET, MRI	> Full range of non-invasive imaging > Echo, EKG
Procedural	> 6 operating rooms (2 eye rooms) > 2 procedural rooms	> 6 operating/procedural rooms

Predictability: With the exception of free standing ERs, all of the patients receiving services in a Level 5 Ambulatory Model are elective and highly predictable in their treatment patterns. Those that are not predictable (ER patients) are generally self-contained within the ER or of such low volumes that they do not disrupt the high-efficiency, fast-turnaround nature of the campus. This predictable nature allows the Level 5 ambulatory model to operate more like a focused factory than even small community hospital settings.

Efficiency and costs: With predictability comes greater efficiency. Efficiency coupled with reduced supporting infrastructure (few 24 hour services) and lower cost facilities results in the ability to contain costs better than alternative delivery mechanisms.

Conclusion

Using this systematic approach, hospitals and health systems can quickly plan, identify and execute a successful ambulatory strategy to better organize and coordinate care for their patient populations. This framework provides a clear model for organizing future ambulatory services to best serve the patients in their specific communities. ■

Kate Lovrien is a senior strategy manager from Kurt Salmon's Minneapolis office. She has focused her career on advising community and regional referral hospitals and healthcare systems on their strategic and physician alignment challenges. Kate is the lead author of the Physician-Hospital Alignment Diagnostic located at www.PhysicianHospitalAlignment.com. She can be reached at (612) 865-6088 or Kate.Lovrien@kurtsalmon.com.

Luke Peterson is the national director of Kurt Salmon's Health Care Strategy Practice. He has focused his career on advising community and regional referral hospitals and healthcare systems particularly on the physician-hospital relationships and healthcare system organizational structures and roles. He can be reached at (612) 810-8188 or at Luke.Peterson@kurtsalmon.com.

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1 http://www.hcplive.com/print.php?url=pc_online_physician_consultations; January 21, 2009

2 Emerg Med J 2010;27:186e188. doi:10.1136/emj.2009.073056

Orchestrating Four Generations in Your Hospital

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

People are living longer and retiring a lot later. I was recently introduced to a land developer from Louisiana who was in her 70s but she looked a lot younger. In fact, she had participated in four triathlons just this year.

In many workplaces it is not unusual to see four distinct generations: the "Veterans," born before 1946, the Baby Boomers, born 1946-1964, Generation Xs, born 1965-1980, and Generation Ys, born 1981-2000, also known as Millennials or Echo Boomers.

These diverse groups need to work together toward a common goal. How well do they get along with each other? Not so great, according to a 2009 survey by the Pew Research Center. The poll uncovered the following findings:

Almost eight in 10 people polled saw a major difference in point of view between younger people and older people. That is the widest gap since 1969, the heyday of the "generation gap," when about 74 percent reported major differences.

Younger people saw differences over lifestyle and relationships; middle-aged people saw difference in manners; and older people cited differences in "a sense of entitlement."

About 75 percent of people age 18-30 said they went online daily, compared with 40 percent of those 65-74 and just 16 percent for those age 75 and older.

While 87 percent of respondents under age 30 said they sent or received text messages, only 11 percent of those 65 and older did so.

Don't let differences harm operations

It is pretty clear that we are generationally more diverse. According to the guru of generational differences, Greg Hammill, the director of intern and student programs at Farleigh Dickinson University in New Jersey, this is the first time we have had four distinct generations in the workplace at the same time.

"At work," he writes, "generational differences can affect everything, including recruiting, building teams, dealing with change, motivating, managing and maintaining and increasing productivity."

Generational differences can have a big impact on hospitals, where large groups of employees work closely together to heal patients and provide efficient care in an era of sparse resources. If the differences are ignored or misunderstood, the result can bring on calamity. Medical errors in hospitals kill an estimated 100,000 patients a year.

With all that is going on in healthcare, enlightened C-suite executives would do well to study the differences between generations so they could better motivate their people to excel in working in multigenerational teams. This could translate into even more competent, superior patient care.

Some specific distinctions

Mr. Hammill and others identify characteristics that define each age group:

Veterans (age 66 and older): This group believes in hard work, respect for authority, sacrifice, duty before fun and adherence to rules. They give directions and are "command-and-control" personalities.

Baby Boomers (ages 47-65): The largest group in the workforce today, they tend to be workaholics who want personal fulfillment and believe in consensual and collegial relations. Like the Veterans, many Baby Boomers have limited exposure to computers and often do not feel comfortable with the latest gadgets.

Generation X (ages 31-46): They enjoy fun and informality, but they can also be skeptics, challenging others and even asking why a certain assignment has to be done. At the same time, they want structure and direction. They are cautious dealing with money and are savers.

Generation Y (age 30 and younger): This group, the offspring of the Baby-Boomers, is tolerant, goal-oriented and entrepreneurial. Since they grew up with computers and the Internet, they are completely at home with technology.

Some tips on handling culture gaps

Knowing each generation's values and habits can be critical in dealing with employees. For example, veterans prefer a formal memo, while Baby Boomers want to communicate in person and the Gen-Y group prefers e-mails or voice mails.

Differing attitudes and expectations can cause friction between generations. Experts like Mr. Hammill suggest bringing the generations together and asking them to talk about how they could do certain tasks differently. They also offer the following tips:

Don't put Veterans or Boomers on the spot by asking them to demonstrate unfamiliar techniques in front of others. Allow practice time in private.

The Gen-X group wants learning to be fun. They like visual stimulation and don't generally read as much as Baby Boomers and prefer visual illustrations over printed materials.

When teaching the Gen-Y group, provide them with opportunities to interact with colleagues and educators.

In short, each generation has distinct attitudes, behaviors, habits and motivational hot buttons. Recognizing them can make the difference between a hospital that runs smoothly and one that could be on the edge of exploding. ■

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

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3) Access expert views from all sides of the ASC world.

PROGRAM SCHEDULE

Pre Conference – Thursday October 27, 2011

11:30am – 1:00pm	Registration
1:00pm – 5:30pm	Pre-Conference
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 28, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:05pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:05pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 29, 2011

7:00am – 8:10am	Continental Breakfast
8:10am – 12:20pm	Conference

Thursday, October 27, 2011

1:00 – 1:40 pm

A. Key Concepts to Fixing Physician Hospital Joint Ventures Gone South
Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgery Centers of America

B. Business Planning for Orthopedic and Spine Driven Centers
Jeff Leland, CEO, Blue Chip Surgical Center Partners

C. Benchmarking for GI Centers
Robert Estes, VP Operations, and Susan Kramer, Director of Clinical Support, Physicians Endoscopy

D. How Do You Value Your ASC For Sale? What is the Value in a Majority Sale Transaction? Can Hospitals Pay More if They can Convert to an HOPD or Apply Managed Care Contracts? What is the Value in a Sale of a Small Percentage to a Physician?
Jon O'Sullivan, Senior Partner, and Greg Koonsman, Senior Partner, VMG Health

E. Managed Care Negotiation Strategies - Using Transparency and Case Data to Show Payers How ASCs Save Them Money
I. Naya Kehayes, MPH, CEO & Managing Principal, and Matt Kilton, MBA, MHA, Principal and Chief Operating Officer, EVEIA HEALTH Consulting and Management

F. Infection Control in ASCs - Best Practices and Current Ideas
Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

1:45 – 2:25 pm

A. Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits
Rob Westergard, CPA, CFO, Susan Kizirian, COO, and Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, Ambulatory Surgery Centers of America

B. Developing a Spine Driven ASC: the Essentials for Success
Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

C. Ophthalmology, ENT and Podiatry in ASCs - Key Thoughts and Trends
Jeff Peo, Vice President, Development & Acquisitions, Ambulatory Surgery Centers of America

D. Should You Sell Your ASC? - A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process
Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgery Centers of America. Introduced by Scott Downing, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods, LLP

E. Should You Outsource Billing and Collections or Keep It in House?
Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source-Medical Solutions, Revenue Cycle Solutions

F. Effective Clinical Benchmarking and Infection Control
Regina Robinson, Director, Peninsula Surgery Center

2:30 – 3:05 pm

A. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them
Reed Martin, Chief Operating Officer, Surgical Management Professionals

B. What Percentage of Key ASC Specialties Will be Employed by Hospitals Within 5 Years - Orthopedics, GI and Ophthalmology
Brian Mathis, Vice President, Strategy, Surgical Care Affiliates, Mike Lipomi, CEO, Surgical Management Professionals, Jimmy St. Louis, III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners, and moderated by Amber McGraw Walsh, Partner, McGuireWoods LLP

C. An Introduction to a Retirement Concept Tailored to Physicians and Doctors Groups
Steven D. Schaumberger and Ken Crabb, JR Katz

D. Physician-Hospital Joint Ventures - How to Resolve Conflict and Keep the Venture Thriving
Dawn McLane, Regional VP, Health Inventures, and Tom Yerden, CEO, TRY Healthcare Solutions

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E. Being a Great Administrator - Core Concepts to Develop Raving Physician Fans
Joe Zasa, JD, Managing Partner, ASD Management, and Stephanie Stinson, RN, BSN, CASC, Administrative Director, Strictly Pediatrics Surgery Center

F. How to Determine When To Go In-Network vs. Out-Of-Network
Rob Murphy, President, Murphy Healthcare Group

3:10 – 3:50 pm

A. Assessing the Future Demand for ASCs, A Panel Discussion
Barry Tanner, President & CEO, Physicians Endoscopy, Brian Mathis, Vice President Strategy, Surgical Care Affiliates, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Impact of Healthcare Reform on Physician Practices and ASCs
Charles "Chuck" Peck, MD, CEO, Health Inventures

C. Key Thoughts From Great Medical Directors - Managing Expenses and Managing Physicians
Alfred McNair, MD, Steven Schuleman, MD, and moderated by Nap Gary, Chief Operating Officer, Regent Surgical Health

D. Anti-Kickback and Stark Act Compliance - Common Issues for ASCs
Scott Becker, JD, CPA, Partner, Melissa Szabad, JD, Partner, and Lainey Gilmer, Associate, McGuireWoods LLP

E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements Valuation and Other Issues
Jen Johnson, CFA, Managing Director, VMG Health

F. Meaningful Use, EMR and Other Key IT Issues for ASCs
Marion K. Jenkins, PhD, FHIMSS, Founder, CEO, QSE Technologies, Scott Palmer, President & COO, Ambulatory Surgery Center Division, SourceMedical Solutions, Jeff Blankinship, President & CEO, Surgical Notes, Faris Zureikat, Administrator, North Texas Surgery Center, USPI, Holly Carnell, Associate, McGuireWoods LLP

Roundtable Discussion
Establishing and Operating Successfully in a Small Market
Joseph Zasa, JD, Partner, ASD Management, and TK Miller, MD, Associate Professor, Dept. of Surgery, VTC School of Medicine, Medical Director, Roanoke Ambulatory Surgery Center, Carilion Clinic Orthopaedics/Sports Medicine

3:55 – 4:30 pm

A. Orthopedics and Spine - Physician Payor Relationships and Evolving Changes
John Cherf, MD, MPH, MBA, President, OrthoIndex, Steven H. Stern, MD, MBA, Vice President, Cardiac & Orthopaedics/Neuroscience, and Michael R. Redler, MD, The OSM Center, moderated By Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Private Equity's Role in and View of the ASC Market
Joe Clark, EVP & Chief Development Officer, Surgical Care Affiliates, David F. Bacon, Jr., CEO, Meridian Surgical Partners, Geoffrey C. Cockrell, Partner, McGuireWoods LLP

C. Revenue Capture for Endoscopy Centers - Best Practices and Great Ideas
Linda K. Peterson, CEO, Executive Solutions for Healthcare

D. ASC Litigation - Can Non-Competes be Enforced? What to Do When the FBI or OIG Calls? How to Work with Payors
Jeffrey C. Clark, Partner, and David J. Pivnick, JD, BBA, Associate, McGuireWoods LLP

E. What is Great and What is not Great Physician Leadership for Your ASC
Brad Lerner, MD, Summit ASC

F. Evaluating the Return on Investment: Outsourcing Key Business Office Operations
Kim Woodruff, Vice President Corporate Finance & Compliance, PINNACLE III

4:30 – 5:30 pm - KEYNOTE

Climbing Up the Mountain - One More Time
Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, Hall of Fame NBA Basketball Player

5:30 – 7:00,
Networking Reception, Raffles and Exhibits

Friday, October 28, 2011

8:00 am

Introductions
Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 8:45 am - KEYNOTE

The View from Washington: Politics, Healthcare Reform and the 2012 Election
Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

8:50 – 9:30 am – General Session

ASCs, Healthcare and Washington DC
Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgery Centers of America, Tom Mallon, CEO Regent Surgical Health, Michael E.Russell, II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Tom Price, MD, U.S. Congressman, Moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:35 – 10: 20 am - KEYNOTE

A. KEYNOTE - How the Best Managers use Recognition to Accelerate Performance
Adrian Gostick, Author and Global Thought Leader on Workplace Strategy

B. The ASC Association Legislative Priorities - and What We Will See for the Next Five Years
William Prentice, JD, Executive Director, and Steve Miller, Director of Government and Public Affairs, Ambulatory Surgery Center Association

C. How to Evaluate & Implement New Profitable Services into an ASC
Robert Zasa, MSHHA FACMPE, Founder, ASD Management, and Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine

D. ACOs in Action

11:25 – 12:10 pm

A. The State of the Unions for ASCs
Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

B. Interventional Pain Management - What the Next Few Years Will Look Like
Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

C. Hospital and Physician Alignment in the Wake of Healthcare Reform - The Expectations for the Next Five Years
Kate Lovrien, Senior Manager, Kurt Salmon and Associates

D. What are the Key Issues Facing Great ASC Administrators
Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, Tracey Hood, Administrator, Ohio Valley Ambulatory Surgery Center, Brooke Smith, Administrator, Maryland Surgery Center for Women, and moderated by Susan Kizirian, COO, Ambulatory Surgery Centers of America

12:15 – 1:00 pm

A. Developing a Strategy for Your ASC
Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Mike Doyle, CEO, Surgery Partners,

B. Endoscopy Centers - Key Trends and Issues
Frank Principati, COO and Frank Coll, VP New Business Development, Physicians Endoscopy

C. Orthopedics and Spine in ASCs - Key Trends and Ideas
John D. Atwater, MD and Richard A. Kaul, MD, Board Certified Minimally Invasive Spine Specialist & Owner, New Jersey Spine and Rehabilitation, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

D. Anesthesia in ASCs
David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

E. Accreditation 101, Everything You Need to Know About Accreditation
Bernard McDonnell, DO, Healthcare Facilities Accreditation Program

1:00 – 2:00 pm
Networking Lunch & Exhibits

2:00 – 2:40 pm

A. The Best Ideas to Improve Volume and Profits
Bryan Zowin, President, Physician Advantage, Inc., John C. Steinmann, DO, Renovis Surgical Technologies, Robin Fowler, MD, Executive Director and Owner, Interventional Management Services, and Keith Metz, MD

B. ASC Turnaround Case Study, From Zero to Wow!
Joseph Zasa, JD, Managing Partner, ASD Management, and Daniel C. "Skip" Daube, Jr., MD, FACS, Founder, Surgical Center for Excellence, Panama City

C. Is There Still Room for Joint Venture ASCs in the Physician-Hospital Integration Tool Kit - The Pros and Cons to ASCs
Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, Ambulatory Surgical Centers of America

D. Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues?
Kristin A. Werling, Partner, Geoffrey C. Cockrell, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods LLP

2:00 – 3:25 pm

E. Managed Care Contracting - 1) How Do You Align Your ASC with Physicians 2) Update on CMS Payment System and How it Impacts on Negotiations 3) Fee Schedule Numbers and Ensuring Revenue Collection from Contracts

I. Naya Kehayes, MHP, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

2:00 – 2:40 pm

F. CMS Inspections Surveys; Are You Ready?

Tracy Hoeft-Hoffman, Administrator, Hastings Surgery Center

2:45 – 3:25 pm

A. The Best Ideas for Physician-Hospital Alignment

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, Charles "Chuck" Peck, CEO, Health Inventures, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, Robert Boeglin, MD, President, IU Health Management, and moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Surgeon Hospital Partnerships Models

Jeff Simmons, Chief Development Officer, and Bo Hjorth, Vice President, Business Development, Regent Surgical Health

C. Developing an Outstanding ASC Quality Program That Can be Implemented and Makes a Difference

Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

D. Physician-Owned ASCs and Hospitals - The Best Strategies for the Next Five Years

Michael J. Lipomi, MSHA, President & Chief Executive Officer, Surgical Management Professionals

F. Governing Body Documentation, Meeting CMS and Accreditation Requirements

Sandra Jones, FHFMA, LHRM, CASC, Ambulatory Strategies, Inc.

4:00 – 4:30 pm

A. Extreme Makeover: Surgery Center Edition - Lessons Learned From a Dozen Turnaround Projects

Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners

B. Ophthalmology in ASCs, Key Issues

Edward Glinski, DO, Healthcare Facilities Accreditation Program

C. Endoscopy Centers - Taking Steps to Prepare an Endoscopy Center for Sale - How to Maximize Your Transaction

Jonathan Vick, President, ASCs, Inc.

D. Helping Large Specialty Physician Groups Navigate the Next Few Years

Marc Steen, Market President, USPI

E. Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Key Valuation Issues

Todd J. Mello, ASA, AVA, MBA, Principal & Founder, HealthCare Appraisers, Inc.

F. Direct Marketing to Patients to Increase Case Volume

Jimmy St. Louis III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners

4:35 – 5:05 pm

A. Q&A Panel: Will Evidence Based Medicine Kill Spine? Will Practice Acquisitions by Hospitals Kill ASCs? Should ASCs Employ Physicians? Where are the Profits in Pain Management?

Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Thomas J. Pliura, MD, JD, PC, Physician & Attorney at Law, zChart, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals and Thomas J. Chirillo, SVP Corporate Development, Surgery Partners

B. Physician-Owned Distribution Companies - Doing It The Right Way

John C. Steinmann, DO, Renovis Surgical Technologies

C. Urology Issues for ASCs

Herbert W. Riemenschneider, MD, Riverside Urology, Inc.

D. Trends in Buying and Selling ASCs: Mergers and Acquisitions of Surgery Centers

Patrick Richter, Vice President Business Development USPI, Blayne Rush, President, Ambulatory Alliances, Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

E. Key Compliance Risks in ASC Billing

Bill Gilbert, Vice President, AdvantEdge Healthcare, and Brice Voithofer, Vice President, ASC Services

F. The Most Common Medical Staff Issues and How to Handle Them

Thomas J. Stallings, Partner, McGuireWoods LLP

Roundtable Discussions

2:00 - 2:40 pm

Physician-Owned Ancillaries - Device Companies, Anesthesia, Pathology and Pharmacy and More

Richard Kube, MD, CEO, Founder & Owner, Prairie Spine and Pain Institute, John C. Steinmann, DO, Renovis Surgical Technologies

2:45 - 3:25 pm

Capital Markets Update - Key Thoughts from Lead Investment Strategists/Managers

Gregory D. Miller, Senior Investment Advisor, and Beata Kirr, Senior Portfolio Manager, Sanford C. Bernstein & Co., LLC

4:00 - 4:30 pm

Metrics and Improving Performance

John Seitz, CEO, Ambulatory Surgical Group

4:35 - 5:05 pm

Are We Profitable? Driving ASC Performance Through Effective Financial Management

Rajiv Chopra, Principal & Chief Financial Officer, The C/N Group

5:05 – 6:30 pm

Networking Reception, Raffles and Exhibits

Saturday, October 29, 2011

8:15 – 9:00 am

A. The 5 Best and Worst Specialties for ASCs - An Outlook for the Next Five Years

Larry Taylor, CEO, Practice Partners in HealthCare

B. Improving Revenue Capture: Best Practices in Coding, Documentation and Charge Capture

Rosalind Richmond, Coding Compliance Officer, and Yvonda Moore, Director of Implementation, GENASCIS

9:05 – 9:45 am

A. The Role of the Medical Director and Physician Leaders in ASCs

John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center

B. Optimizing Business Office Performance

Paul Davis, CPA, CMA, Amblitel

C. Infection Prevention in ASCs: Looking Ahead - What Does the Future Hold

Marilyn Hanchett, RN, CIC, Senior Director, Clinical Innovation, APIC

D. What Should Great Medical Directors, Administrators and DONs be Paid?

Moderated by Rachel Fields, Managing Editor of Becker's ASC Review, ASC Communications, Inc.

9:50 – 10:30 am

A. The Best and Worst Procedures for ASCs and What an ASC Should Get Paid

Matt Lau, Director of Financial Analysis, Mike Orseno, Revenue Cycle Director, and Vivek Taparia, Director of Business Development, Regent Surgical Health

B. Determining the Exact Cost of a Procedure

Terry Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital

C. Infection Prevention and the CMS Infection Prevention Mandate for ASCs: Key Strategies to Enhance Performance

LoAnn Vande Leest, RN, MBA-H, CNOR, Chief Executive Officer, and Fawn Esser-Lipp, The Surgery Center, LLC

D. How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, GI and Ophthalmology Procedures

Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting

E. The Future Is Now, Preparing You and Your Practice for a Changing Environment

Pedro Vergne-Marini, MD, Founder and Managing Member, Physicians' Capital Investments

10:35 – 11:15 am

A. 3 Core Orthopedic and Practice Group Initiatives - Hospitals and Ancillaries Service Line Management Agreements and Becoming Leaner

John Martin, CEO, OrthoIndy

B. Examining Every Aspect of the Supply Chain to Develop Great Cost Savings

Scott Benglen, CEO, Via Novus Medical, LLC

C.Environmental Cleaning & Disinfection - Best Practices

Jack Wagner, President & Founder, Micro-Scientific Industries

D. Ophthalmology in ASCs - Current Trends and Issues

Michael A. Romansky, JD, Washington Counsel, VP for Corporate Development, Outpatient Ophthalmic Surgery Society

E. Advanced Benchmarking of Financial and Clinical Results

John Goehle, CASC, MBA, CPA, Ambulatory Healthcare Strategies, LLC

11:20 – 12:20 pm

Key Legal Issues and Legal Compliance Boot Camp - The Core Elements of a Successful Compliance Plan

Scott Becker, JD, CPA, Partner, Lainey Gilmer, Associate, and Amber McGraw Walsh, Partner, McGuireWoods LLP

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- Michael R. Redler, MD, The OSM Center
- Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians
- David E. "Buddy" Bacon, Jr., CEO, Meridian Surgical Partners
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Adrian Gostick

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- John Byers, MD, Medical Director, Surgical Center of Greensboro Orthopaedic Surgical Center
- Daniel C. "Skip" Daube, Jr, MD, Founder, Surgical Center for Excellence, Panama City
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CONFERENCE SPEAKERS

John D. Atwater, MD

Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine

David F. Bacon, Jr., CEO, Meridian Surgical Partners

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Scott Benglen, CEO, Via Novus Medical, LLC

Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners

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Big Changes Ahead: Medicare IPPS 2012 and What It Means for Hospitals ***(continued from page 1)***

familiar connection with the scenario — particularly in light of the Centers for Medicare & Medicaid Services' changes to the IPPS. These rules, going into effect Oct. 1 for fiscal year 2012, contain payment rate changes, coding adjustments, and the quality reporting program, which mandates hospitals to report on 55 measures for FY 2012.

More than 60 percent of hospitals already lose money on Medicare, according to the American Hospital Association. Section 3401 of the Patient Protection and Affordable Care Act detailed across-the-board Medicare payment reductions for hospitals. These cuts are estimated to reduce reimbursements by $155 billion from 2010-2019, a strategy hospitals agreed to accept in 2009 to help fund healthcare reform. While good news for CMS, these additional Medicare cuts could prove devastating to hospitals, particularly when paired with extensive performance-based healthcare delivery reforms, such as value-based purchasing, which is set to begin in Oct. 2012.

Putting the IPPS into context

From an academic and legal standpoint, Craig B. Garner, a professor of law at Pepperdine University in Malibu, Calif., says the proposed changes are fascinating. "Throughout its history, Medicare has employed variations of cost-based reimbursement, originally factoring in the actual cost to a provider and then transitioning to a predetermined rate based upon a patient's particular diagnosis. Soon it may not matter anymore," says Mr. Garner. "The new regulations are changing a very complex system and steering it in a totally new and equally complicated direction, only this time based on performance. This will include what people think of a hospital, the patient experience during a hospital stay, and ultimately the reliability of a hospital in its delivery of patient care," says Mr. Garner.

The release of the proposed IPPS rule in April was met with a subdued reaction compared to the distaste that followed the publication of the proposed rules for accountable care organizations. Few organizations issued written responses to CMS throughout the IPPS comment period, which ended June 20. The final rule was released August 1 and was similar to the final rule with some changes. Instead of the 0.55 percent net cut to hospital payments included in the proposed rule, the final rule included a 1.1 percent net increase in hospital payments.

Doing the math

While more lengthy than the proposed rule, the final rule generally constituted a more "generous" reimbursement package for hospitals, though hospitals will still face financial pressures. For example, under the final rule, a 300-bed hospital with $250 million in revenue in FY 2010 will need to reduce costs by more than $2 million in FY 2012 to maintain Medicare margins at the level they were in FY 2010, according to "Medicare Zero," a white paper Mr. Perez co-authored. That finding is based on this rationale: The intent of the market basket update is to offset increases in hospital input prices, so in theory, its effect should be margin-neutral. (For FY 2012, the final unadjusted market basket update is 3.0 percent.)

However, there are adjustments to the market basket update, and if the sum of them is negative, added pressure is placed on hospitals to maintain margins. For FY 2012, these adjustments include a 0.1 percent reduction to the market basket update and a productivity adjustment of -1.0 percent

Doing the math: IPPS 2012

+ 3.0	unadjusted market basket update
- 0.1	percent per PPACA
- 1.0	percent per PPACA
- 2.0	final documentation and coding improvement prospective cut
+ 1.1	percent restoration of rural floor budget neutrality agreements
+ 1.0	net payment increase for FY 2012

(both per the Patient Protection and Affordable Care Act), a final documentation and coding improvement prospective cut of -2.0 percent, and a 1.1 percent increase (to restore rural floor budget neutrality adjustments). These adjustments total -2.0 percent and account for the estimated $2 million required cost reduction for a hospital with 300 beds. (Combined with the unadjusted market basket update of 3.0 percent, the net payment increase for FY 2012 is 1.0 percent.)

The spectre of future cuts

The debt-ceiling deal signed into law by President Obama on Aug. 2 tasks a 12-person joint select congressional committee to come up with $1.2 to $1.5 trillion in deficit reduction by Nov. 23. According to Mr. Perez, "As a preliminary analytical exercise, if you assume that Medicare will bear its proportionate share of the cuts, $150 to $200 billion in cuts to Medicare could be expected over the ten years. If one further assumes that 100 percent of the cuts will be covered by reduced reimbursements to providers (currently a more politically popular approach than reducing Medicare benefits) and that the IPPS would bear its proportionate share of the cuts, we estimate that the IPPS would be cut by $50 to $65 billion over the ten years. That would translate into a cut of $1.1 to $1.4 million per hospital per year."

Value-Based Purchasing and performance periods

It is separate from IPPS and won't kick in for another year, but hospitals shouldn't rest on their laurels and brush the Value-Based Purchasing program to the sidelines. It presents another instance where hospitals will be based on their performance, which is being measured this very moment.

The VBP program, as outlined in Section 3001 of PPACA, is based on measures used in the Hospital Inpatient Quality Reporting program. This includes 17 processes of care measures, claims-based measures, structural measures and patient experience measures as indicated by the HCAHPS survey. VBP isn't set to kick in until Oct. 1, 2012. Hospitals that improve outcomes or achieve certain performance standards, compared to their baseline performance, will receive incentive payments for discharges occurring on or after that time. Still, hospitals have already been measured and are currently in the midst of another performance period.

Quality data collected from July 1, 2009-March 31, 2010, will serve as the baseline for determining hospital's quality improvement. One year later, July 1, 2010-March 31, 2011 was known as the "performance period." Data collected from this timeframe (clinical process of care and patient experience) will be used to determine hospitals' achievement scores. This information will be compared to the national performance standards that were derived from the baseline period data. But that's not all — hospitals are being measured now for 30-day mortality rates for the FY 2014 VBP program. This 12-month reporting performance period goes from July 1, 2011-June 30, 2012.

No relief from commercial payers

One should not assume that hospitals will be able to simply shift costs to commercial payers to offset downward pressures on Medicare reimbursement, either. A recent research report from Morgan Stanley predicts that commercial payers, facing financial challenges themselves, will increasingly prove unable to afford to offset pressure on government reimbursement rates, thus placing greater pressure on hospitals to contain costs.

Historically, lower Medicare rates drove an uptick in commercial rates. Morgan Stanley has predicted that commercial cost-shifting onto consumers will now drive greater focus on healthcare costs. Commercial payors may now employ more aggressive care management and tighter networks, making their reimbursement an unlikely back-up option for hospitals that are feeling Medicare's squeeze.

How can hospitals breakeven?

Behind the number-crunching stands a simple fact: It's impossible for any hospital to trim millions of dollars from its budget to reach breakeven and meet the requirements of VBP and other healthcare delivery reform mandates without serious changes to its core operations. Mr. Perez recommends hospitals focus their efforts on improving the efficiency and effectiveness of their care delivery.

To that end, strengthening partnerships with physicians is one of the four strategies Mr. Perez discusses in "Medicare Zero." Hospitals can identify the 10 MS-DRGs, or Medicare severity diagnosis-related groups, that are causing the hospital to lose the most money. By monitoring clinician adherence to best practice protocols and treatment programs, hospitals can reduce or eliminate variations in care for certain DRGs.

Hospitals should consider the elimination, reduction or combination of service lines that are unprofitable. Outsourcing the management of certain service lines may reduce costs while also maintaining or improving outcomes. On the other hand, high-volume and profitable service lines should be expanded. By analyzing market demand, hospitals can offer new services and attract new physicians or patients by doing so. Still, changes in staffing might be a likely option for many hospitals to pursue. The reduction of overhead costs, such as operating room utilization, can be accomplished through stricter scheduling and process standardization. ■

How to Achieve Accountable Care While Avoiding Downfalls of Medicare ACOs

By Sabrina Rodak

Most people in healthcare agree that the triple aim of accountable care organizations — increased quality of care, improved health of populations and reduced cost — are worthy goals that healthcare should focus on. How to reach these goals, on the other hand, is a question that garners many different answers. The Centers for Medicare and Medicaid Services' proposed Medicare ACOs have received much backlash from professional organizations and individuals criticizing its retrospective assignment of patients, number of quality metrics and shared savings rate, among other provisions. In fact, a survey conducted by *U.S. News & World Report* and Fidelty Investments found that while 33.2 percent of hospital executives said it is extremely likely their hospital will become part of an ACO, only 6.8 percent believe ACOs can improve quality and efficiency. In an effort to modify CMS' structure of ACOs while staying true to its triple aim, organizations have developed various pilot projects and models for integrated care, including patient-centered medical homes and private payor-provider relationships.

Accountable care

"Our point of view is that accountable care itself is something that is absolutely here to stay and [something] healthcare delivery organizations really need to get their arms around," says Jordan Battani, a principal researcher in CSC's Global Institute for Emerging Healthcare Practices, the applied research arm of CSC's Healthcare Group. Regardless of which model organizations choose, they should begin preparing for a transformation of the way care is delivered. "I don't think you can overemphasize the need for organizations to start thinking about [accountable care] and get themselves in motion," says Ms. Battani. "A prudent business decision would be to focus on the reimbursement requirements for these [accountable care] models; it's also very important not to get distracted by those, because they will change."

One way to prepare is to start aligning with other healthcare organizations, not only to streamline processes and create efficiencies, but also to access sufficient capital and other resources needed to create and sustain an accountable care model. "Providers need to understand and start preparing for the possibility that a significant amount of revenue not only for the commercial market, but also for Medicare and Medicaid, is going to come through some form of accountable payment methodology," says Rob Parke, a principal at consulting firm Milliman. Delivering high quality on a fixed budget "requires integration and infrastructure, which means you need to come together to accumulate capital." Below, experts discuss the merits of different pay-for-performance models and how they compare to the Medicare ACO model as it is currently proposed.

Patient-centered medical homes

The patient-centered medical home is a model that may be relevant to health systems with employed primary care providers that are still working toward a fully integrated ACO. The PCMH model is are currently being tested by CMS, and many private payors are embarking on initiatives based on this model as well. The PCMH model is designed to refocus healthcare on primary care and the patient. "The patient-centered medical home is a set of principles and model of revitalizing primary care, which has become marginalized, underresourced disconnected and disempowered in nature largely as a result of our current reimbursement schema," says David Nace, MD, vice president and medical director of RelayHealth, a division of McKesson, and vice chairman of the Patient-Centered Primary Care Collaborative board. Similar to the Medicare ACO model, the PCMH is centered around primary care. "The goal of the patient-centered primary care movement is to empower a robust, comprehensive, contemporary, continuous and connected primary care base that can serve as the cornerstone of a more accountable healthcare system," Dr. Nace says.

The PCMH can meet some of the goals of the proposed Medicare ACO by using patient data to manage population health, following up with patients post-treatment and providing alternatives to costly emergency room or urgent care visits. As in the proposed Medicare ACOs, PCMHs use a team approach to care for the patient. In the PCMH model providers will remind patients of their medication regimen and other requirements to keep them out of the hospital. The medical home will also use evidence-based guidelines to deliver care. Unlike the Medicare ACO, however, the medical home does not have as many quality metrics providers need to meet in order to benefit from shared savings, a provision many organizations have spoken out against. Another potential benefit of PCMHs is less burnout in providers because they can spend more time with patients who truly need their services and direct patients who do not need their services to other resources, such as retail clinics.

The PCMH model may not replace the Medicare ACO model, but instead form a building block of the ACO or function as a separate entity that may introduce providers into the accountable care world. From this perspective, Medicare ACOs will function similarly to PCMHs, but on a larger scale. Mina Harkins, assistant vice president of recognition programs at the National Committee for Quality Assurance, says Medicare ACOs and PCMHs are "two separate things that work together quite well."

Because PCMHs work on a smaller scale than the proposed Medicare ACOs, they offer providers a way to begin their transition to a more comprehensive model of accountable care. Despite individually being smaller scale, Peggy Naas, MD, MBA, vice president of physician strategies at VHA, believes PCMHs may be more effective in aggregate at bending the cost curve than Medicare ACOs. "My concern is that the number of American healthcare providers who feel both capable of and willing to participate in Medicare shared savings programs with the current proposed rules and regulations is a very small subsection of our provider organizations. And therefore, it's going to provide, even if successful, a small bending of the total cost curve. It's not going to be the model that creates a fundamental shift in the majority of healthcare providers," says Dr. Naas. She believes PCMHs may be more attractive to providers because the medical home model seems more secure and less risky and still allows the building of accountable capabilities. "It's still challenging. It's not like people are picking an easy way out, but it's a little more predictable," she says.

Private payor-provider relationships

Many private health insurance companies have begun partnering with hospitals and physicians to coordinate services and align incentives, which allows providers more flexibility than Medicare ACOs in negotiating terms such as shared savings rates, the population of patients and quality metrics. "The more sophisticated hospitals that take control of this [relationship] will be able to negotiate a more attractive deal for themselves because there's more flexibility. They will be able to structure deals in a way to help transform the organization over time rather than being locked into the model Medicare has chosen," Mr. Parke says. This greater flexibility may allow more healthcare providers to participate in accountable care because arrangements can be tailored to meet each provider's needs "rather than the one-size fits all Medicare shared savings plan," according to Mr. Parke. Arrangements with private payors can be designed around a certain episodes of care as opposed to the entire continuum of care and, in some cases, may offer greater financial reward. For example, sophisticated hospitals may profit more from entering into a bundled or capitated payment model compared to a shared savings model. Furthermore, private payor models can also involve a more diverse population and allow for prospective assignment of patients instead of retrospective assignment as the proposed Medicare ACO model would use.

An additional benefit of arrangements with private payors is easier access to resources needed to manage the health of populations. "Private payors already have in place some infrastructure that is required to be successful in an ACO-like model," Mr. Parke says. For instance, private payors can provide capital and technology for data analytics that can help providers track patients' health. "It's going to be very challenging for organizations trying to transform into [accountable care models] without the support of organizations to provide data and aid in a change in reimbursement," Raena Grant Akin-Deko, assistant vice president of product development for NCQA, says. "A lot [of organizations] are beginning to partner with health plans to provide data and differential reimbursement to build a sustainable model."

Although commercial payor arrangements can eliminate many of the downfalls of the proposed Medicare ACOs through its flexibility, the model still presents challenges to healthcare organizations. Providers and payors will have to form relationships differently than they have in the past. "One of the collaborative care models that has arisen is payor-provider realignment, which is usually found in areas where the performance of a health system is below national benchmarks, prompting payors and providers to work together in a more collaborative fashion than in the past in order to improve outcomes," says Todd Cozzens, CEO of Accountable Care Solutions at Optum. In addition to the challenge of relationships with payors, providers also need to manage the requirements of different payors it contracts with. "One of the struggles that Medicare is facing is that most providers in the community have relationships with and are reimbursed by many different payors. If one payor is asking them to do one thing and another something different, it's very hard to keep track of what all the initiatives are," Dr. Nace says. Leadership from Medicare, however, may allow for more consistency across payors. "The nice thing about Medicare is most of the private [payors] try to follow. Once Medicare does something, private initiatives start to do something. The key is can they align their approach," Dr. Nace says.

Future of healthcare delivery

Regardless of which model providers choose, it seems inevitable that healthcare organizations will need to practice accountable care to succeed. The needs of each organization will dictate how they adopt this principle — whether by participating in the Medicare ACO, a patient-centered medical home or a private payor ACO. Each accountable care model involves greater collaboration between providers across the continuum of care, greater coordination of care and the use of data to track population health. These changes will require a great deal of time and effort of healthcare providers.

"Hospitals are going to be challenged in this accountable care world to change their business model. In the current fee-for-service world, attracting specialists is the business model. Once they start shifting into an accountable care type world, [they will] need to transform into population-based thinking where primary care physicians become the [basis of the business model]," says Mr. Parke.

One of the challenges in any accountable care model is the implications of its success. "If this move to accountable care is successful, the need for hospital services will go down," Mr. Parke says. If organizations reach the goal of improving the health of populations, they will need to manage the effects of decreased demand for services. "If medical homes are really successful, there may be 20 percent fewer inpatient hospital admissions," Dr. Naas says. Hospitals will need to develop a plan for reallocating resources to accommodate a drop in admissions. However, hospitals are not likely to face this challenge soon because undergoing a change as significant as accountable care will be a long-term process. "It's taken us 50 plus years to get in this spiral of healthcare cost inflation and utilization patterns. It's not going to untangle itself in 3-5 years," Ms. Battani says. As the rules for the proposed Medicare ACO change and pilot projects release their results, healthcare leaders will need to adapt to new models of care that can reach the triple aim. ■

Survey: 33% of Hospital Executives Plan to Join ACOs, But Less Than 7% Believe Model Improves Quality

By Molly Gamble

In a survey of executives at 1,852 hospitals, 33.2 percent of respondents said it is extremely likely their hospital will become part of an accountable care organization — but only 6.8 percent believe ACOs can improve quality and efficiency.

The full-length Hospital Executives Survey, conducted by *U.S. News & World Report* and Fidelity Investments, posed the following questions pertaining to ACOs and physician-hospital relationships. The following questions pertain to ACOs and physician-hospital relationships. Responses for the first two questions are presented on a 1-5 scale, with 1 meaning "extremely likely" and 5 "not at all likely."

How likely is it that over the next three years, your hospital will become part of an ACO?

1 — 33.2 percent

2 — 33.2 percent

3 — 22.8 percent

4 — 6.8 percent

5 — 3.7 percent

How likely is it that over time ACOs will significantly improve the quality and efficient delivery of healthcare?

1 — 6.8 percent

2 — 26.8 percent

3 — 36.9 percent

4 — 19.7 percent

5 — 9.5 percent

What is the priority, over the next three years, of increasing the percentage of your hospital's budget devoted to marketing your hospital to physicians and patients to generate more referrals?

1 (high priority) — 6.8 percent

2 — 25.8 percent

3 — 36.3 percent

4 — 21.5 percent

5 (low priority) — 9.5 percent ■

5 Foundational Questions for Hospitals Acquiring Physician Practices

By Bob Herman

Physicians are increasingly joining hospitals as employees, signaling interest from both hospitals and physician practices to partner together. According to the Medical Group Management Association's 2010 physician placement report, roughly 65 percent of established physicians were placed in hospital-owned practices, up from its 2008 report that showed a figure closer to 50 percent.

Hospitals looking to acquire a physician practice have a lot of things to consider, especially with recent healthcare legislation taking effect and accountable care organizations and other pay-for-performance models formulating. The following are five questions hospitals should ask before acquiring a physician practice, a trend that has only been on the rise for hospitals and physicians alike.

1. How do you find interest? Like any business transaction, there has to be a willing buyer and a willing seller, says Larry Fitzgerald, CFO of the University of Virginia Health System in Charlottesville. It's not hard for hospitals to find willing physician practices today, as many are looking for alternative business models due to pricey electronic health record implementation, malpractice litigation and general overhead costs. "[Physician practices] are in a difficult time dealing with the compliance issues, billing issues, criteria of different payors, procedures being pre-authorized, and a significant amount of overhead costs," Mr. Fitzgerald says. "There's an enormous amount of bureaucracy, and small physician groups are looking for a safe harbor."

James Dan, MD, president of Advocate Medical Group in Chicago, came from the private practice realm years ago. He says hospitals are gradually going to be more responsible for the cost of care, and with the recent healthcare reform and economic downturn, both hospitals and physicians are seeing the prospects of joining forces. "Financial pressures are clearly causing private physicians across the country to look up and around and ask, 'What are my options?'" Dr. Dan says. "Medium-term private practice will be difficult, and hospitals have concerns about healthcare reform and services they will no longer be paid for."

2. Which physician practices should be considered? There are numerous types of physicians practices, ranging from cardiology and primary care to dental and optometry, that may be looking for hospital alignment. Choosing one and evaluating it are the crucial steps as an acquisition gets under way. Dr. Dan says when acquiring physician practices, it's important to find those that have hospital care as a major part of their practices because that is where the synergy is. Primary care physician practices have been the most commonly sought-after practices, but specialty practices are garnering increased looks among hospital leaders today as well. These specialty physicians include cardiologists, oncologists and neurosurgeons among others.

Recently, Midwest Heart Specialists in Oak Brook, Ill., agreed to affiliate with Advocate, and Dr. Dan says reimbursements for specialties such as cardiology revolve around hospital care. "Cardiologists are beginning to approach en masse very much at the same time hospitals face healthcare reform," Dr. Dan says, and evaluating the physician practices' needs with those of the hospital or health system must fall in line.

3. What issues arise with physician compensation? The key phrase, from both a legal and business perspective, when it comes to paying physicians is "fair market value." Paying physicians fair market value is the baseline, and Dr. Dan says an improvement in benefits and the offering of a stable hospital or health system environment are usually two other incentives that make a compensation methodology successful.

Mr. Fitzgerald notes that not giving physicians a straight salary is an important component, as compensation in the current era should be based on both productivity and value of the physician. "Hospitals made mistakes in the 1990s by giving them a salary not tied to productivity," Mr. Fitzgerald says. "They were giving them a high base salary, and the doctors realized they can work eight hours today or nine hours today and can make the same amount of money. The very key point of the sustainability of the business after acquiring a physician practice is a payment arrangement that is based on productivity with an emphasis on quality and patient satisfaction."

Dr. Dan echoes that sentiment, saying a hospital's compensation methodology that is also based on reducing unnecessary care and improving outcomes, or value-based compensation, is increasingly becoming a part of the compensation climate.

4. What types of physicians should be sought after? Mr. Fitzgerald says the trend back in the 90s was to search for primary care physicians only and to avoid specialty care. With the uncertainty of how ACOs will look, he says specialty physicians are now sought after just as much in order to keep a health system vertically integrated. "Five years ago, a trend started to surface to accumulate both primary care physicians and specialty care physicians under the health system umbrella," Mr. Fitzgerald says. "That trend has continued and accelerated, and I think it is likely to accelerate into the future."

Mr. Fitzgerald also notes that a hospital or health system must assess each physician at a basic level to see what is motivating them. For example, buying a physician practice with a physician nearing retirement and perhaps looking for a retirement package is a way a healthcare organization should clearly identify a scenario, he says. Whether a hospital or health system should continue a transaction with a retiring physician ought to be handled on a case-by-case basis.

In the end, the quality of physician is of utmost importance, Dr. Dan says. Malpractice liability is a challenge for any hospital or practice, and while he says there can be a Russian roulette aspect to individual malpractice suits, practicing safe medicine is a built-in mantra of any healthcare entity. "Doctors are not a commodity," Dr. Dan says. "A cardiologist is not a cardiologist; it's how that person practices medicine. Quality counts."

5. How do you provide mutual support? At the core of any successful relationship, healthcare-related or otherwise, is a sense of trust and support between the two interested parties. Dr. Dan says acquired physicians need to have a sense of trust with the hospital administration and to feel their support as if they are a part of the new team. There needs to be a governance of physician leadership that can both articulate their points of view but also show the hospital or health system's willingness to make things work. "The valuation and compensation side may satisfy a financial appetite, but you need to create a setting that is professionally satisfying, too," Dr. Dan says. "You can't emulate a large, bureaucratic organization that makes them feel like they are another cog in the wheel." ■

Pennsylvania's Divine Providence Hospital Settles Improper Payment Allegations

By Molly Gamble

Divine Providence Hospital in Williamsport, Pa., agreed to pay the federal government $598,965 to resolve allegations of improper Medicare claims in June. The payment will settle allegations that, from Jan. 2004-Dec. 2007, the hospital erroneously submitted Medicare payment claims that contained evaluation and management services not allowable under Medicare. A spokesperson from Williamsport-based Susquehanna Health, the hospital's parent company, attributed the errors to a "good-faith" interpretation of Medicare's regulatory language. ■

Federal Investigation Looks for Stark, Anti-Kickback Violations at Broward Health

By Molly Gamble

Agents from the inspector general of the Department of Health and Human Services issued Fort Lauderdale, Fla.-based North Broward Hospital District, also known as Broward Health, a subpoena May 17 to review contracts given to more than 27 physicians for violations of Stark and Anti-Kickback laws. The agents said they issued the subpoena in connection with an investigation over possible false claims to Medicare and Medicaid relating to physician reimbursements. ■

Community Health Systems Receives SEC Subpoena

By Lindsey Dunn

Community Health Systems, based in Franklin, Tenn., said it received the subpoena on May 13 requesting documents related to various inquiries into the company's billing practices. The practices allegedly resulted in one-day admissions that should have been billed as observation status visits. The hospital operator is also being investigated by the Department of Justice and HHS following a lawsuit by Tenet Healthcare alleging improper billing resulting from the admission practices. ■

Florida's St. Luke's Hospital Faces False Claims Allegations

By Molly Gamble

In May, a former hospital employee filed a lawsuit accusing St. Luke's Hospital in Jacksonville, Fla., of falsely billing the government from April 2008 until March 2009. The suit claims the hospital was ineligible for Medicaid and Medicare payments because its accreditation allegedly transferred when St. Vincent HealthCare took over St. Luke's from former operator Mayo Clinic. St. Luke's allegedly continued claiming Mayo's accreditation as its own when it was under St. Vincent HealthCare's ownership. ■

6-Year-Old Whistleblower Suit Against IASIS Healthcare Alleging Kickbacks is Dismissed

By Molly Gamble

A whistleblower's complaint against Franklin, Tenn.-based IASIS Healthcare, which claimed the 19-hospital system paid kickbacks in exchange for referrals, has been dismissed by a federal judge in Arizona. U.S. District Judge Robert Clive Jones rejected the complaint from Jerre Frazier, former vice president of ethics and compliance for IASIS who filed the complaint against IASIS in March 2005. Mr. Frazier claimed the system performed unnecessary medical procedures and illegally paid physicians for patient referrals to pad profits. In Jan. 2011, IASIS filed a motion to dismiss Frazier's complaint and also filed a renewed motion for sanctions concerning Mr. Frazier's "misappropriation and misuse of privileged documents." ■

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12 Decisions That Can Cripple a Surgery Center

By Rob Kurtz

Brent Lambert, MD, founding principal, and Luke Lambert, CEO, of ASCOA, make regular visits to ambulatory surgery centers throughout the United States which are struggling financially and in need of a turnaround. They say some of these facilities can be saved because, fortunately, the poor choices made by the owners are correctable over time. Unfortunately, that's not true for all of these ASCs.

"We actually look at a lot of centers we don't think we can fix because of decisions made," says Luke Lambert.

Here are 12 decisions (or "fatal flaws" as Dr. Brent Lambert terms them) which they have seen cripple an ASC.

1. Overbuilding. One of the most common mistakes they see is when physicians have grandiose plans and therefore overbuild their facility. "We've seen a center with four ORs and yet they're only doing 150 cases a month," says Luke Lambert. "That fixed cost of the large center is a long-term burden for a relatively low volume facility."

Dr. Brent Lambert says this hurts physicians two ways: "It hurts the doctors who spend all this money on the build-out but then it's a [double-edged] sword because they're spending all this money for rent."

2. Expensive lease. The signing of a lease that's too expensive is a related mistake to overbuilding, says Luke Lambert. "Physicians sometimes feel like they need to be in a fashionable location for their facility," he says. "Of course, none of the payors pay you extra for being in a fashionable location."

3. Signing contracts without negotiating. Another mistake made by startup ASCs seen quite frequently occurs when a physician group is anxious to start using their new center to perform procedures that they will sign any contract offer from the payors without negotiating the rates.

"That locks them into payment rates that can be very disadvantageous over the long term," says Luke Lambert. "They may be busy right away but maybe they don't make money because they signed on to rates that were too low. Once you're doing the cases, it's very hard to negotiate them upwards.

"Your point of greatest negotiation advantage is when the cases are being done at a high-cost place, like the hospital, and you're offering to move them to the low-cost place, like your new ASC," he says. "If you demonstrate a willingness to leave them in the hospital unless you're given a good contract, that's your best position of negotiation."

4. Terminating contracts but keeping the cases in an ASC. The most leverage ASC physicians have over payors is their ability to dictate where they perform their procedures. Sometimes physicians who are frustrated with the rates they are receiving will terminate a payor's contract with the threat of taking the cases out of their ASC in order to gain this leverage. But instead of taking the cases to a high-cost place, they will take them to another ASC.

"This doesn't cost the payor any more money so [the physicians] don't achieve any leverage," says Luke Lambert. "If you want leverage, you have to take your cases to a high-cost place like the hospital."

5. Holding on to hospital block time. Oftentimes, new ASCs are started by physicians well-established in their careers, says Luke Lambert. They may have spent many years influence peddling and cajoling to optimize their schedules and earn what they see as their perfect block time at a hospital. When these physicians open their ASC, it is conceivable that half of the time they were spending at the hospital performing procedures should now go to the ASC. For some specialties, it might be all of their time. But this doesn't always happen.

"Because so much of their professional life was spent obtaining that block time, they don't want to give it up," he says. "To try to maintain it, they don't take everything they could to their own ASC. They sort of starve their center and keep sprinkling cases into their [hospital] block so they don't give up what they see as almost a prime piece of real estate."

6. "Hijacking" the ASC by senior partners. Dr. Brent Lambert says he regularly sees situations where senior surgeons nearing retirement will "hijack" their ASC. "They don't want the monthly distributions to stop," he says. "If there's no language for redemption at time of retirement, they actually prevent any [language] from getting into the bylaws and the operating agreement of the center, so these guys will have income for life."

He notes one ASC which was distributing checks to physicians for 10 years after they retired, and says he has seen situations where anywhere from a quarter to a half of the physicians receiving checks are non-performers.

"It's discouraging for the people in [the ASC], it destroys the morale," Dr. Brent Lambert says. "We don't allow that. The moment they retire, they are redeemed at fair market value."

7. Formation of an executive board. In some ASCs, a few dominant physicians will convince the other physicians that the facility needs an executive board or committee to make the significant decisions for the facility. Whatever name they assign to it doesn't matter to Dr. Brent Lambert as it means only one thing to him: a red flag.

"If we're acquiring an ASC with an executive board where three guys are speaking for 20, we don't allow it," he says. "We say everybody has one vote so it can't be dominated by these three people. If they're fighting to maintain this executive committee, my antenna goes up and I ask why it is so important for them. Then you start seeing medical director fees or even board fees in some of these places."

8. Plastic surgeons as partners. Another common mistake seen is when an ASC brings one or two plastic surgeons into the partnership. "The plastic surgeons can be very persuasive, they can use a lot of the center, but if they're cosmetic plastic surgeons, we've rarely seen them as profitable," says Luke Lambert.

The challenge with plastic surgeons who focus primarily on cosmetic procedures and see these cases in the ASC is that the surgery center will often unintentionally subsidize the professional payments of the plastic surgeons.

"Let's say the plastic surgeon wants the ASC OR for an hour and will pay $400," Dr. Brent Lambert says. "That's a money loser for an ASC." The plastic surgeon may find a hospital willing to offer that rate, so the ASC tries to compete with that pricing to keep the physician happy and performing procedures at the surgery center.

"These plastic surgeons have a global fee of let's say $25,000 for a facelift," Dr. Brent Lambert says. "Out of that they have to pay the facility fee, anesthesiologist fee and themselves. If they can cut the facility fee by two-thirds, then they get to keep it. If you allow a plastic surgeon partner to have a room for $400 when they really should be paying $1,000 or $1,200, then the ASC is basically handing the plastic surgeon money.

"If a plastic surgeon has ORs at the local hospital for $400-$500/hour, and he's going to be in the ASC, he wants the ASC to match those rates and then the center loses money," he says.

The ASC would be better off letting the physician take these procedures to the hospital, but then the surgery center still has the problem of a non-performing physician-owner.

9. Physician involvement with human resources. When a physician becomes involved in the hiring and firing of staff, it can cause many challenges for an ASC. For example, if a surgeon critical to the surgery center's volume and income hires a family member or significant other to a staffing position, if there is ever a problem with this staff member, it becomes a problem for the entire facility.

"They're the favorite of this doctor … and they know they don't have to produce anymore because they have a virtual lifetime employment contract," says Dr. Brent Lambert. "Those kinds of staffing/HR problems can really corrupt a center and cause wholesale defections of the other staff that see this and they know what's going on. It's very demoralizing; the other partners don't like it. It can destroy the chemistry of the center."

It is scenarios like this which make it critical for ASCs to keep their physicians out of the human resources component of the operations and task hiring and firing to an independent person.

10. ASCs built in or near physicians' offices. In today's market, it's becoming harder for a single practice to support an ASC effectively, says Luke Lambert. Many practices will develop their ASC in a real estate space that is either in or next to their office. That affiliation or perceived connection between the practice and the ASC can create challenges for recruiting additional surgeons.

"Maybe they're an orthopedic practice and they want to recruit the other orthopedists in town," says Luke Lambert. "The other orthopedists aren't going to want to send their patients to another practice for their surgery. This can create a problem for growing the center and keeping it viable long term."

11. Lack of rules for conduct. Every surgery center should, as part of its bylaws, include rules for proper conduct which applies to all physicians and staff members who work at the ASC.

"You have to protect your employees from some of the surgeon-partners (and also staff members) who may have obstreperous personalities that offend and create hostile work environments," says Dr. Brent Lambert. Without rules of conduct and clearly spelled-out ramifications for violating the rules, an ASC could quickly lose its staff because of the actions of a single person.

"Some partnerships are very cognoscente of this so they put it into their documents," he says. "If [a physician] ever does such and such, we'll give him a warning. If he ever does it again, he's redeemed."

Luke Lambert says this challenge is most often seen in smaller centers where 1-2 partners are very dominant. "The reason they tend to be small centers is other people don't put up with it as partners or they may have started small but have been unable to grow because these types of issues keep people away," he says.

One of the advantages of a corporate partner is the ASC has a disinterested third-party who can adjudicate such situations, Dr. Brent Lambert says. "You can't write a document that covers everything," he says.

12. Physician-owners stuck in a single-specialty dream. Many physicians who open an ASC envision it at the start as a single-specialty entity which will help to define who they are as surgeons, and they cannot fathom cohabiting the facility with any other specialty, says Dr. Brent Lambert. This, he says, is a huge flaw in the thinking of ASC owners.

"They envision this single-specialty orthopedic (for example) ASC that they walk to from their office," he says. "They have a rehab facility on the same floor for their total joint patients. They come up with an idealized dream of what would be a perfect ASC.

"Well, if you look around the country, there are all of these single-specialty ASCs not thriving," he says. "They haven't been making any money for years and [the physician-owners] have had to feed the ASC cash in order to maintain this single-specialty status, which means nothing. It actually is a huge detriment to them. If they could bring in other specialties and cover their costs, they would be distributing money but instead they're fixed on this dream concept. It's the height of ego fulfillment." ■

Key Issues Plaguing Physician-Hospital Joint Ventures

By Lindsey Dunn

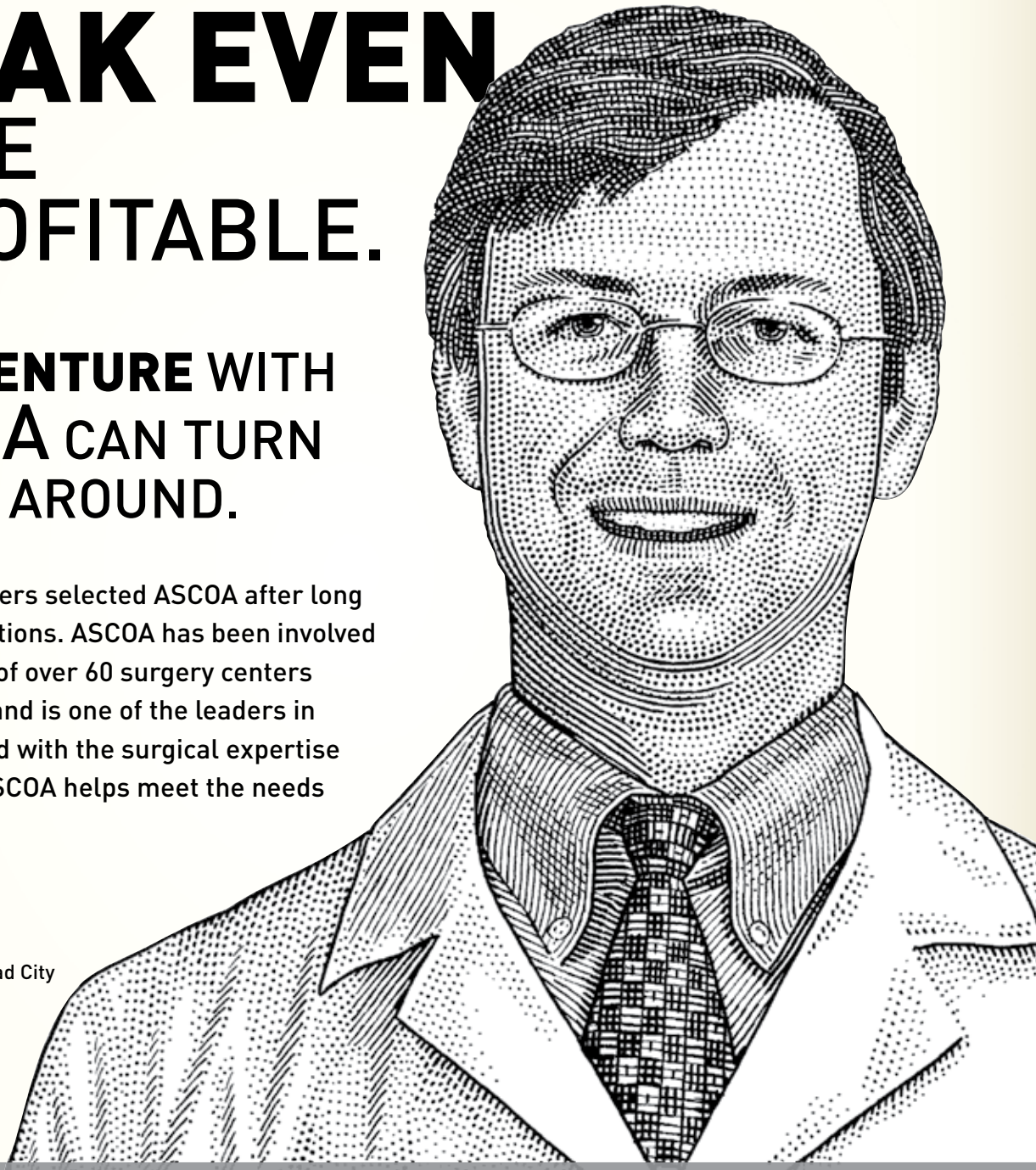
Nearly half of surgery centers in the country are struggling, meaning they are losing money or close to breaking even, says Luke Lambert, CFA, CASC, CEO, ASCOA, While many struggling ASCs believe partnering with a hospital means an automatic improvement in performance, Mr. Lambert cautions many ASCs experience little to no performance improvement after partnering with a hospital.

He attributed this largely to the fact that in more than 90 percent of hospital-physician joint ventures, hospitals have a larger ownership stake than physicians, and he claims hospitals have less impetus to make the center as efficient as possible than may be present under a physician-controlled model. "Other than for reimbursement, there is no reason for hospitals to be in control," he says. Although he adds, hospitals can be helpful in physician recruitment.

However, there are situations when hospital control may be necessary, including:

- **Certificate of Need required** — In CON states, a hospital partner is likely to improve the center's chances of receiving approval for construction of a new facility.
- **"Bump" in reimbursement needed** — Because hospitals have more leverage than ASCs, allowing the hospital to contract for the center may lead to improved payment rates with commercial payors. Most payors require hospital control of the ASC in order to include the center in the hospital's overall contract. However, Brent Lambert, MD, FACS, principal and founder, ASCOA, cautions that because ASCs are not core facilities for the hospital, contracts often fall short. He encourages ASCs considering a hospital partner to ask outright what specific percent increase in reimbursements they

50% OF HOSPITAL-OWNED ASCs BREAK EVEN OR ARE UNPROFITABLE.



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can expect and to be cautious of a partner that can't provide a definite answer.

Physician control as a key to ASC success

While majority-hospital ownership may be needed to address these issues, the most successful joint-venture ASCs limit the percentage of hospital ownership to no more than 51 percent, says Mr. Lambert.

Additionally, many successful joint-ventures centers are managed by physicians or an ASC-management corporate partner as opposed to a hospital, which may not have experience managing a freestanding ASC, says Dr. Lambert.

Dr. Lambert suggests troubled hospital-physician ASCs find ways to increase physician-control in the center and consider bringing in a corporate partner experienced at running freestanding ASCs in addition to traditional improvement measures such as renegotiating payor contracts, recruiting new surgeons, reducing staffing costs to 21 percent of collections and reducing supply costs to no more than 20 percent of collections. ■

50 Surgery Center Benchmarks

By Rachel Fields

Here are 50 benchmarking statistics on processes and outcomes at ambulatory surgery centers across the country. Data is compiled from ASC Association surveys, VMG Health's Multi-Specialty Intellimarker and SDI's Outpatient Surgery Profiling Solution.

Net revenue, OR time and outcomes

The following statistics on net revenue are based on data from VMG Health. The statistics on surgery center OR time and outcomes are based on data from the ASC Association's Outcomes Monitoring Project 2nd Quarter 2010 Report.

Average surgery center net revenue: $6,833,000
Average total operating expenses: $4,881,000
Average EBITDA: $2,001,000

Median operating room time per patient encounter: 50.2 minutes
Average procedure room time per patient encounter: 34.2 minutes
Median rate of unscheduled direct transfers: .6 transfers per 1,000 patient encounters

ASCs using a patient satisfaction survey: 99.5 percent
ASCs completing 90 percent of medical records in 30 days: 78.5 percent
ASCs reporting 0 wrong site, side, procedure, implant, patient procedures: 94.7 percent

Case volume, payor mix and staff hours

The following statistics on case volume, payor mix and staff hours per case are based on data from VMG Health's Multi-Specialty Intellimarker 2010.

Case volume
Total cases per center: 4,698
Cases per day: 18.8
Surgical cases per OR (annually): 705
Surgical cases per OR (daily): 2.8
Non-surgical cases per procedure room (annually): 1,169
Non-surgical cases per procedure room (daily): 4.7

Payor mix
Medicare: 25 percent
Medicaid: 5 percent
Commercial: 59 percent
Workers' comp: 6 percent
Self-pay: 5 percent
Other: 7 percent

Staff hours per case
Nurse hours per case: 6.2
Tech hours per case: 2.6
Administrative hours per case: 4.4
Administrator hours per case: 0.6
Total hours per case: 11.0

Affiliated physicians
The following statistics on affiliated physicians are based on data from SDI's Outpatient Surgery Center Profiling Solution, which profiles 81,597 physicians performing procedures at ASCs.

Number of affiliated physicians per ASC
1-5 physicians — 47 percent
6-10 physicians — 18 percent
11-15 physicians — 9 percent
16-25 physicians — 10 percent
26-50 physicians — 10 percent
More than 50 physicians — 6 percent

A/R and Compensation

The following statistics on surgery center accounts receivable and compensation are based on data from the ASC Association's 2010 ASC Employee Salary & Benefits Survey and the ASC Association's Outcomes Monitoring Project 4th Quarter 2010 Report.

Accounts receivable
All reporting ASCs — 39.7 days
Multi-specialty ASCs — 40.3 days
Single-specialty ASCs — 39.2 days
Gastroenterology single-specialty ASCs — 30.1 days
Ophthalmology single-specialty ASCs — 37.0 days
Orthopedic single-specialty ASCs — 52.8 days

Average 2010 Salaries
Certified registered nurse anesthetist: $156,000
Administrator: $93,870
Registered nurse: $60,500
Business office manager: $53,000
Anesthesiologist: $275,000
Instrument technician: $33,280
Operating room technician: $40,000
Managers eligible for bonuses:
- Administrators – 75 percent
- Business office managers – 63 percent
- Directors of nursing – 64 percent
- Materials managers – 53 percent
- Medical directors — 10 percent ■

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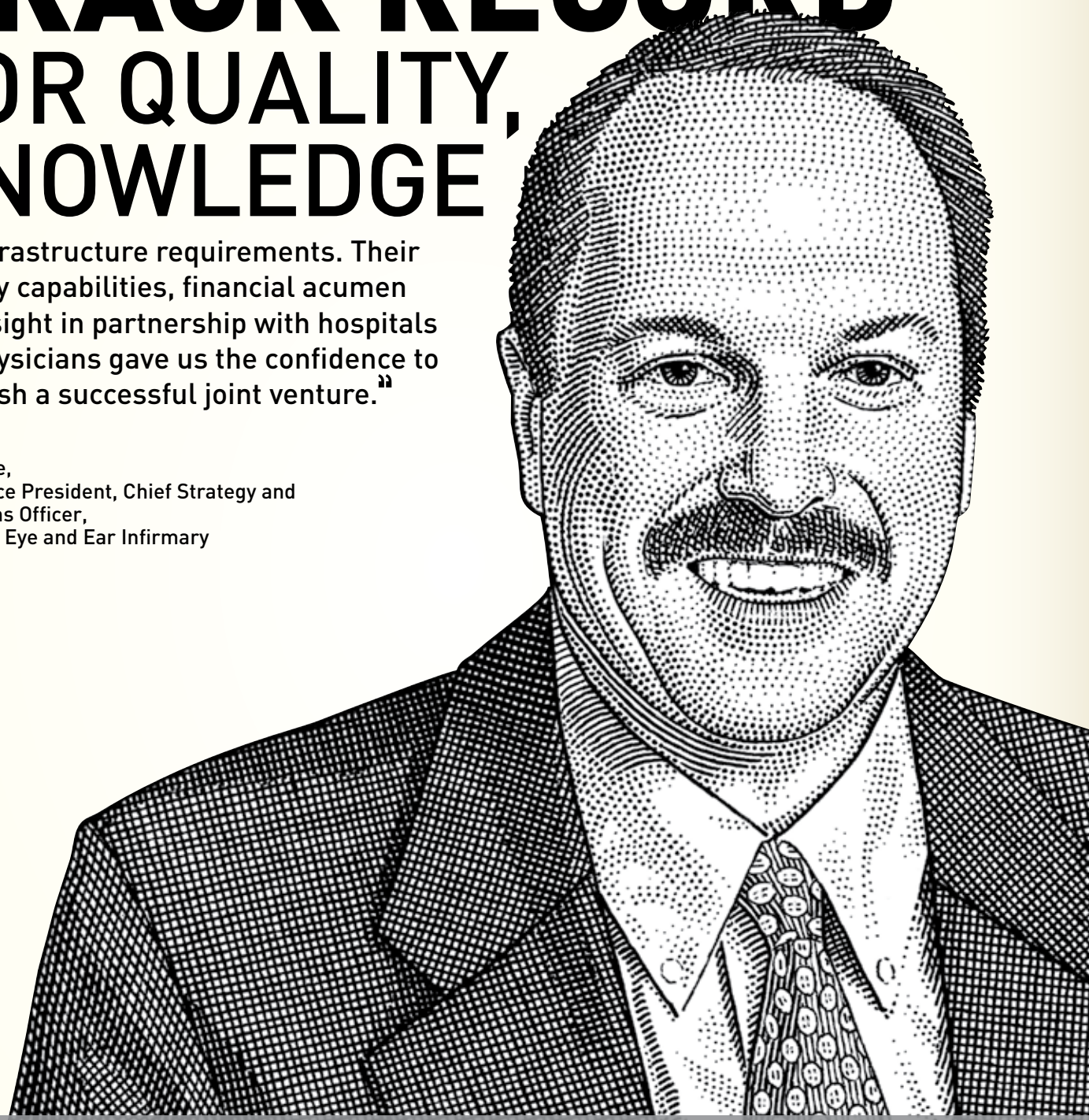
Allan Fine,
Senior Vice President, Chief Strategy and Operations Officer,
New York Eye and Ear Infirmary



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How Healthcare Reform is Affecting Hospital Leaders' Compensation

By Sabrina Rodak

Healthcare reform legislation, including changes in requirements for tax-exempt hospitals and initiatives by the Centers for Medicare and Medicaid Services for coordinated care, may change how hospital leaders are compensated. While these changes do not directly affect hospital compensation, they may indirectly affect salaries through increased regulations and different models of care delivery. Gary Young, director of the Northeastern University Center for Health Policy and Healthcare Research, explains what changes for-profit and non-profit hospitals may expect as healthcare reform laws start to take effect.

Tax-exempt status

The Internal Revenue Service recently proposed community health needs assessment guidance for tax-exempt hospitals, including a provision that hospitals perform a community health needs assessment every three years. The proposed rules and changes under the Patient Protection and Affordable Care Act "do not speak directly to hospital executive compensation, but are important symbolically because they reflect a growing concern on the part of policy makers regarding the justification of providing federal income tax exemption to non-profit hospitals and what the differences are between non-profit and for-profit hospitals," Mr. Young says.

Mr. Young believes the new tax-exempt provisions for hospitals signal a shift to greater scrutiny of non-profit hospitals, which may include greater scrutiny of executives' compensation. "Collectively, the provisions reveal greater concerns about holding tax-exempt hospitals accountable for their performance relative to community benefit," he says.

Non-profit hospital leaders' compensation is expected to align with the local labor market. Non-profit hospitals need to provide evidence that the executives' pay is not excessive by comparing their compensation with that of leaders in similar organizations. "It's not so much whether salaries are high as whether they can be justified based on what is necessary to hire someone to do the job the hospital needs that individual to do," Mr. Young says.

Effect of ACOs

The introduction of the accountable care organization model may change hospital leaders' compensation through changing patient volumes and leadership structures. These factors may have opposite effects, making it difficult to predict exactly how hospital executive compensation might shift over the next couple years. For instance, Mr. Young says financial incentives for keeping people out of the hospital may result in hospitals reducing their capacity, which may decrease leaders' compensation. At the same time, if hospitals play a central role in ACOs' formation, they may receive increased compensation to reflect increased responsibility, Mr. Young says.

While both non-profit and for-profit hospitals can participate in ACOs, for-profit hospitals may have easier access to capital, through shareholders, needed to start this type of organization. Mr. Young says this financial pressure, in addition to greater regulations concerning the justification of non-profits' compensation, may trigger some non-profit hospitals to become for-profits. "Some hospitals may decide that they can't meet those [tax-exempt] standards or that the exemption that they're receiving isn't worth meeting those standards. It may in fact be a catalyst for them to convert [to for-profits]," Mr. Young says. ■

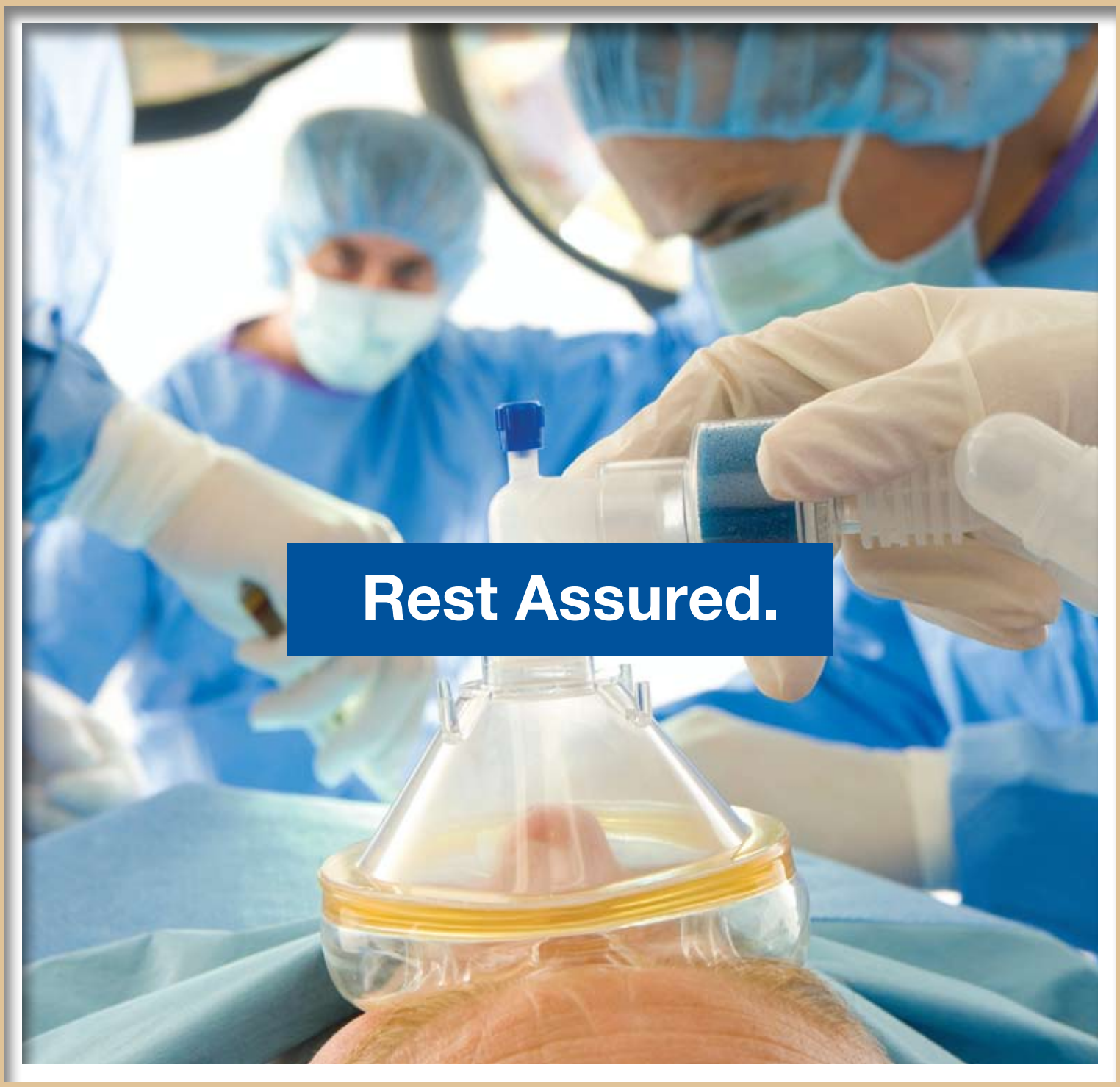
On-Call Coverage Payments Increased 4% in 2010

By Sabrina Rodak

Payment rates for on-call coverage increased 4 percent in 2010 compared to 2009, according to the 2010-2011 Physician Contract Benchmarks Reports by MD Ranger.

The report found several factors that influence on-call payment:

- Trauma status had an average 26 percent premium to coverage rate.
- On-site coverage increased payment rates by an average of 35 percent.
- Restricted coverage increased payment rates by an average of 19 percent.
- Each additional increase of 10 occupied beds in a hospital's average daily census increased payment 1.2 percent. ■



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Independent Hospital CEOs Beat Integrated Health System CEOs in Total Cash Compensation Increases

By Sabrina Rodak

In 2011, integrated health system CEOs and independent hospital CEOs saw an increase in total cash compensation — base salary plus annual incentives — of 3.1 percent and 6 percent, respectively, from the previous year, according to a Hay Group news release.

The 2011 Hay Group Healthcare Compensation Study also showed a median base salary increase of 4 percent for non-profit integrated health system CEOs and 5 percent for independent hospital CEOs.

Other data points include the following:

- Planned median base salary for integrated health system employees increased 3 percent, slightly more than the 2.3 percent increase for independent hospital employees.
- Seventy-nine percent of providers use patient satisfaction as the primary measure for annual incentives across all executive employee groups of the organization.
- Twenty-eight percent of health systems have reviewed their annual incentive plans in the last two years. ■

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5 Considerations on Health Information Exchanges: What Your Hospital or Health System Needs to Know

By Bob Herman

Hospitals and health systems are scrambling to become meaningful users of certified electronic health record technology within their own entities, but what's the next step to share health information after that step? The answer for many organizations will be health information exchanges.

HIEs mobilize patient healthcare information electronically across multiple member organizations, hospitals and other stakeholders. In many ways, it's like an EHR for an entire geographical region or, on a smaller scale, a health system that gives physicians and other healthcare professionals secure access to patient data when it might be needed in critical moments. The following five considerations can give hospitals and health systems more insight on what an HIE is and what the benefits and drawbacks of joining or creating one are.

1. Nuts and bolts. For a HIE to work, hospitals and health systems must first have functioning EHR systems, preferably ones that satisfy the Office of the National Coordinator for Health Information Technology's requirements for meaningful use. Federal grants through the HITECH Act are helping hospitals and health systems adopt EHRs, and the ONC has been funding states to implement HIEs. The State HIE Cooperative Agreement Program has awarded more than $547 million to 56 states, eligible territories and qualified state designated entities, according to the ONC website. Providers wanting to join a HIE look for a basic starting point: where is there a HIE geographically closest? Health systems wanting to create their own must decide if it is financially and logistically feasible to interlink member hospitals.

With EHRs in place, the HIE organization can recruit different providers, hospitals and health systems to join the exchange in order to share patient information. For example, Tom Penno, chief operating officer of the Indiana Health Information Exchange, says patients can go to a physician, have blood work completed and that information can be uploaded if they see other physicians or specialists within the HIE. This gives the provider a new way to obtain patient information quickly and securely at crucial points of care, he says. Joy Grosser, vice president and chief information officer of Iowa Health System, says HIEs make it possible for clinicians and physicians to have all the information they need to give the best possible care to patients, be it in a clinical, ambulatory or hospital setting.

"HIEs are really an infrastructure necessity to change the way we're doing healthcare across regions, states and the nation," Ms. Grosser says. "Most people don't spend their entire life at one hospital or one physician. It's integral to help manage the healthcare of a population to be able to share this info. We're on the first step of a stairway through this process."

2. Implications of health IT vendors. According to a recent eHealth Initiative survey, HIE initiatives are up nine percent from last year, so there is a demand when it comes to HIEs and vendors to build their infrastructures. Consequently, hospitals wanting to join a HIE or build their own are at a time of both early adoption but, as the survey shows, a growing demand. There are dozens of HIE vendors, many of which are similar to a hospital's EHR vendor, but John Hendricks, IT director for interoperability and web programming for Iowa Health System, says knowing the right certified system within the HIE is key. The HL7 Clinical Document Architecture is a standard that all lays out the specific structures and meanings for clinical documents to be exchanged. The Continuity of Care Document is the main document within the HIE and EHR systems, and some include different subject areas of patient health, such as allergies, family history, results, vital signs, payor details and others. Hospitals entering or creating HIEs must be cognizant of the information that is actually being shared and how a vendor handles the sensitivity of the information. Mr. Hendricks notes that not all vendors support the different subject areas and CCDs, and there is not complete interoperability among all different hospital EHR systems.

Ms. Grosser adds that choosing vendors and implementing HIEs is still very new and proprietary for each organization's core IT systems. However, putting certified systems and coding in place is one of the best practices an organization can do, she says. Standardizing those systems with certified nomenclature will lead to less overall confusion between participating providers while sharing information.

3. Main incentives. With the industry emphasis turning to both quality and access, Ms. Grosser says HIEs give health systems, hospitals, patients and all involved in healthcare a more efficient and easier way to administer quality healthcare. "At the point of care, it provides a broader picture for them to take care of the patient," Ms. Grosser says. "Health information exchanges are about caring for the patient." She adds that tests might not have to be done twice, and allergies can be caught earlier if providers have patients' medical histories at their fingertips, regardless of what provider they've been to before.

Mr. Penno has been at the IHIE since it started in 2004, and it is currently the nation's largest self-sustaining HIE, covering the entire nine-county area around Indianapolis as well as numerous communities throughout Indiana. He says he has seen the benefits of an HIE for hospitals and other providers as the IHIE has grown, and one of the biggest incentives he's witnessed is the ability to manage a population better. HIEs allow for better health decisions to be made at the point of contact, and it could lead to providers automatically helping people with chronic diseases such as diabetes or cancer to stay up-to-date on appointments and checkups. "If you give physicians patient-specific alerts and reminders — this lady hasn't had a mammogram, this guy hasn't had a colonoscopy — you become much more proactive in managing their healthcare," Mr. Penno says.

4. Financial and political challenges. Politics and finances go hand-in-hand for many big operations, and Mr. Penno says that's no different for hospitals, health systems and HIEs. Before ARRA and the HITECH Act, he says it was a challenge for hospital leaders to prioritize a HIE in their plans, but now with meaningful use incentives from the government in the future, some of which are still being ironed out for HIEs, it has become easier to attract participants. "It was a challenge to get CEOs and CIOs to return your phone call, but as HIEs came onto the horizon, suddenly they had a vested interest," Mr. Penno says. "They knew that was going to be an important part to achieve meaningful use and incentives."

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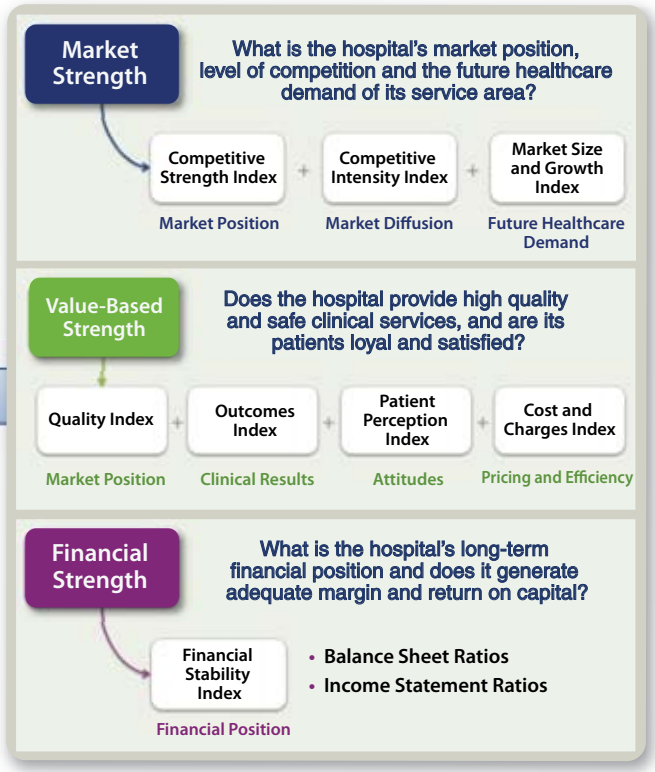

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Still, Ms. Grosser says large regional or statewide HIEs can cost upwards of tens of millions of dollars, and they are more expensive than an internal exchange within a hospital or other healthcare organization. HIEs are still in their infancy, so it will naturally cost more initially, but government-provided grants and meaningful use incentives are the big financial stimulants for both sides, she says.

5. Opt-in versus opt-out. A key for any HIE is to have patient data to share in the first place. There are two approaches a HIE can employ to obtain patient data for its exchange: opt-in or opt-out.

The opt-out approach puts the onus on patients to have their information removed from the exchange. HIEs would have a privacy consent form stating the patients' information might be used for healthcare purposes, but the patient is put into the system as a default. Mr. Penno says the IHIE utilizes the opt-out approach in order to obtain as much patient data as possible, but some sensitive data such as HIV results and behavioral health results would not be included. "You're going to get more people contributing their information," Mr. Penno says. "It could be more important when they're on a gurney in the emergency room, or maybe they are allergic to something."

The opt-in approach, however, puts the onus on the hospital or health system to obtain permission from each patient stating they are opting in to the HIE. While this type of data exchange might not be as robust initially, growing more slowly, Mr. Hendricks says the patient may prefer the opt-in default approach because the patient would have full control of his or her information. "The opt-in default approach establishes transparency between the exchange and the patient," Mr. Hendricks says. "In either case, patient education is a must for health information exchange."

"But the key driver going forward is going to be the patient," Mr. Hendricks adds. "As patient awareness grows, hopefully they will drive the adoption of health information exchanges." ■

Mayo Clinic Constructs Pioneering Health Information Exchange

By Bob Herman

Health information exchanges might be taking a new turn in advancement, as Rochester, Minn.-based Mayo Clinic is building a health information exchange using open-source natural language processing software to create new methods of mining patient data.

The health system is using a federal grant from the Office of the National Coordinator of Health IT's Strategic Health IT Advanced Research Projects program. The SHARP program and grants aim to improve care for patient, provide better health information for specific population and drive down healthcare costs.

Mayo is also working with the Indiana Health Information Exchange to establish a data repository, which could streamline health management and outcomes analysis across numerous populations, the report said. ■

Number of Health Information Exchanges Up 9% Compared to Last Year

By Bob Herman

A total of 255 health information exchanges are in place across the country, a growth of nine percent from last year, as shown in the eHealth Initiative's 2011 Report on Health Information Exchange: The Changing Landscape.

The annual survey also included these other key findings:

- Twenty-four HIE initiatives reported they have sustainable business models, up from 18 in 2010.
- Roughly 25 percent of survey respondents indicated they will support accountable care organizations.
- Eighty-five HIE initiatives offer at least one service that supports the meaningful use requirements.
- At least 10 HIE initiatives have closed or consolidated, but 46 new startups responded to the survey.
- Complex privacy controls for patients remain a high priority and are being developed by HIEs.

A separate study by KLAS found that private health information exchanges are growing more rapidly than public exchanges. According to KLAS, the number of fully operational, public health information exchanges increased from 37 in 2010 to just 67 in 2011, while the number of live private HIEs increased from 52 last year to 161 this year.

Data collected for this report revealed governance and funding are the two main reasons public HIEs are not going live as quickly as private HIEs. Physicians may also be slow to adopt public HIEs due to wariness of lost productivity and concerns over data integrity. ■

Dr. John Caruso: Becoming a Champion of Change in Healthcare

By Molly Gamble

Some healthcare professionals might still be analyzing the Patient Protection and Affordable Care Act, but other physicians are making the legislation — and the ideas behind it — come to life.

John Caruso, MD, is one of those physicians. He has nearly 20 years of experience in neurological surgery and currently practices with Neurological Specialists, a private group in Hagerstown, Md. A physician advocate, Dr. Caruso believes it's time for physicians to become more involved in healthcare economics and policy. Here, he shares his insight on physician-hospital relationships, population health management, and why physicians should broaden their understanding of a hospital's bottom line.

On working with hospitals

Dr. Caruso says physicians' tenure in a community generally outlive those of CEOs. "Philosophies can change quickly in regard to healthcare," says Dr. Caruso. He mentions a friend who once told him CEOs are similar to ball players that frequently relocate and work for different organizations. Young and eager CEOs, however, can make a noticeable difference in a hospital's relationships with other providers in the area. "When you get a CEO that really wants to innovate, that's when you get a home run," says Dr. Caruso.

Tense relations with hospitals are nothing new to Dr. Caruso, who has battled a hospital in his market for the past four years. The hospital saw the private practice as a competitor, taking inpatients away from their spine services. "The hospital saw us as a source of leakage. They fought us tooth and nail. Then they finally admitted that their inpatient volumes had been rising and they were improving their bottom line due to our practice," says Dr. Caruso.

He says hospitals often evaluate things from a service-line perspective, and need to widen their lens to focus on the large picture. His spine practice helped provide follow-up care for hospital patients, which could eventually lead to reduced readmissions. "Inpatient and outpatient care are married; you can't separate the two," says Dr. Caruso.

A sharpened focus on healthcare economics

Healthcare experts often speak on the gap in understanding between the head and the heart of healthcare — the people crunching numbers and the those providing care. As a physician activist, Dr. Caruso has made an initiative to educate himself on the economics, finances and business behind healthcare — the only way he thinks physicians can change the system. He encourages physicians to develop a deep sense of curiosity and become engaged in discussions, collaborations, meetings or other forms of activism to improve healthcare. "You have to understand that healthcare is at risk right now. You've got to realize you can't keep playing by the same rules. Become the champion of that change," says Dr. Caruso.

"It would be wrong for me to sit there and put my head in the sand," says Dr. Caruso. Physicians can no longer turn a blind eye to the cost of the care they provide. "You should become involved in your hospital, understand relationships with other physicians and maximize the economies of scale," says Dr. Caruso.

"You're a back-pain management specialist"

Dr. Caruso realized his field was evolving when one of his peers in the medical community told him he is not a spine surgeon, but a back-pain management specialist. "I thought he was nuts, but he was right," says Dr. Caruso. "He understood the concept that conservative care is the best way to go."

Dr. Caruso's change in mindset reflects a broader change in healthcare: population health management. The three-word term has become a buzzword in the industry, married to healthcare reform since it is believed to reduce spending while boosting efficiency. More physicians are extending the focus of their care to help manage chronic conditions — such as back pain — and serve across the continuum of care rather than episodically. As Dr. Caruso mentions, this can not only benefit the healthcare system but physicians' practice sas well.

Less than five percent of people need surgery of the spine, which is why Dr. Caruso has expanded the musculoskeletal and neuromuscular health focus of his practice. As a result, Dr. Caruso's practice has also expanded its role in the marketplace. Sixty percent of all trauma patients have neuromuscular problems, which automatically ties the practice to inpatient hospital services. "That becomes an energy in and of itself,' says Dr. Caruso. "We are forming a group that expands upon our ability to keep trauma services open." ■

Hospitals and Patient Centered Medical Homes: A Practical Pairing

By Kenneth Bertka, MD, Vice President of Physician Clinical Integration, Mercy Health Partners

Kenneth Bertka, MD, is a family physician and vice president of physician clinical integration at Mercy, a seven hospital and physician group system based in Toledo, Ohio. Mercy is a member of Catholic Health Partners, the largest healthcare system in Ohio.

The patient-centered medical home makes enormous sense, and it's a wonder the American healthcare landscape hasn't included this model all along. PCMHs are considered a fundamental component of healthcare reform, offering rich benefits to both providers and patients. While relatively new, the model is already showing considerable promise in the industry. According to the Patient-Centered Primary Care Collaborative, approximately 13 percent of primary care physicians currently practice in a PCMH. Still, as many as 70 percent of practices are either already in the process of becoming or interested in becoming a PCMH, according to a Medical Group Management Association survey.

In 1967, the American Academy of Pediatrics first introduced the idea of the "medical home" in the context of children with special needs. In its original form, the medical home brought together the services of specialists, primary care physicians, other clinicians and ancillary services to deliver coordinated and comprehensive acute, chronic and preventive care for children with conditions such as Down's syndrome. Over the next three decades, organizations such as the World Health Organization and the Institute of Medicine emphasized the need for medical care based on a primary care model. In 2007, the major primary care physician associations in the United States released the Joint Principles of the Patient-Centered Medical Home.

Coordinated care, accountable care, preventive care — healthcare reform has unleashed a multitude of buzzwords commonly used to describe the same idea. PCMHs, however, are concrete. This model is a specific style of delivery for primary care practices, one that incorporates a team approach, enhanced accessibility and population management. In a PCMH, primary care physicians are part of a team of clinicians, often including health coaches, who engage patients as active participants in their own health. Hospitals and health systems pursuing accountable care need high-performing primary care practices as a foundation, and PCMHs can help hospitals and practices align incentives while delivering coordinated and comprehensive care.

Mercy in Northwest Ohio is participating in a system-wide initiative with Catholic Health Partners to transform our primary care practices to PCMHs. In Toledo, we have included our family medicine residency in the initial group of practices on the PCMH transformation journey. In the residency setting, the focus of the PCMH remains not only on better patient

care but also on the added dimension of training the next generation of physicians in this model of care that emphasizes care teams, data-driven quality improvement and patient-engagement.

Practices within a PCMH are high-performing in every sense of the word. They provide comprehensive primary care services for children, youth and adults, addressing their preventive, acute and chronic needs. These practices offer high-quality care and have strong financial performance. General internal medicine, general pediatrics and family medicine are the most common practices in a PCMH, however, some OB/GYN practices also consider themselves as primary care providers and may opt to transform into a PCMH.

The most common route for recognition as a PCMH is through the National Committee for Quality Assurance. Additionally, in July, the Joint Commission launched a Primary Care Medical Home option for JC-accredited ambulatory care organizations.

The Joint Principles established by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and American Osteopathic Association include:

Personal physician. Each patient has an ongoing relationship with a personal physician who is focused on continuous and comprehensive care as part of a care team.

Physician leadership. Practices are physician-directed and have a team approach to care delivery. All members of the team, including physician assistants and nurse practitioners, are critical to the PCMH mission.

Whole person orientation. The PCMH provides for all of the patient's healthcare needs or takes responsibility for appropriately arranging care with other specialists, clinicians and professionals.

Care is coordinated and integrated. The PCMH works across the complex healthcare system and the patient's community. Information technology plays an important role.

Quality and safety. This includes evidence-based medicine, patients actively participating in decision-making and voluntary participation in quality measurements with a focus on active quality improvement. PCMHs rapidly adapt their policies, procedures and workflows based upon measured outcomes that are patient- and population-based.

Enhanced accessibility. Access to care is available through open scheduling, expanded hours and expanded options for communication between patients and providers, such as patient portals and secure e-mail.

Payment. Fundamental to the PCMH is a recognition that the payment system must change to appropriately recognize the added value of this intense level of primary care. Increasingly, PCMH practices are paid for obtaining quality goals and providing care coordination and management services.

Population health management, a critical characteristic of the PCMH, is a process that most physicians — particularly those in the middle of their professional careers — may not have been trained to provide. Physicians have traditionally been taught to manage or care for one patient at a time. Now we're being asked to do more and to look at our entire population of patients. In the PCMH, physicians need to analyze their population of patients and discover what might be unique about them. In the NCQA recognition process, the PCMH is expected to focus on at least three chronic conditions and one at-risk group within the practice.

As a family physician, I spent the first half of my career in private practice in a suburban location. Now, I practice out of a residency program in the central city of Toledo. Diabetes is a prevalent condition in both locations, but there are different factors that I must recognize as a physician to better tailor my care.

In Toledo's central city, social-economic conditions are more commonly a barrier to care compared to my prior suburban practice population. In my suburban practice, alcoholism and addiction disorders were not uncommon. However, in my current practice population these conditions are more prevalent and often accompanied by abuse of controlled substances. Through population health management, physicians identify the key issues in their communities to better deliver the whole-person care so integral to PCMHs.

Hundreds of PCMH pilots across the country have revealed important trends, such as happier staff, happier physicians, improved practice revenue, increased take-home pay for physicians, a transition to team-based care and an increase in the standardization of care. On the patient side, PCMHs are linked to improved satisfaction, improved preventive care, reduced emergency department utilization, reduced hospital readmissions and reduced per capita cost for certain chronic conditions.

A recent study by Bertakis et al, published in the *Journal of the American Board of Family Medicine,* demonstrated an association of patient-centered care with an overall decrease in health care utilization measured by specialty care, diagnostic testing, hospitalizations and total charges. Although the study group was only 509 patients and the study period was only one year, the 34 percent lower total healthcare charges associated with the group of patients who received more patient-centered care is sure to attract attention of healthcare decision makers looking to "bend the cost curve."

For hospitals and health systems looking to improve the operations of their primary care practices, PCMH conversion may be the answer. In fact, many have turned to TransforMED, a wholly-owned subsidiary of the American Academy of Family Physicians, for guidance with the challenging process of PCMH transformation. Equally, if not more important, those hospitals and health systems planning their clinical integration strategies will likely find linkage to a network of PCMHs fundamental to success. ■

Hospital & Health System Transactions

Bert Fish Medical Center in New Smyrna Beach, Fla., has officially ended its merger with **Adventist Health's Florida Hospital** in Orlando. Bert Fish has returned to public control, under the **Southeast Volusia Hospital District**.

Capella Healthcare in Franklin, Tenn., officially acquired a 60 percent ownership interest in Woodbury, Tenn.-based **Cannon County Hospital**. CCH owns **DeKalb Community Hospital** in Smithville, Tenn., as well as **Stones River Hospital** in Woodbury, Tenn. The transaction involved a subsidiary that owns a majority interest in Sparta, Tenn.-based **White County Community Hospital**, which is affiliated with Capella.

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

Elyria, Ohio-based **EMH Healthcare**, **Parma (Ohio) Community General Hospital** and **Southwest General Health System** in Middleburg Heights, Ohio, have formed the for-profit organization Community Health Collaborative.

Geisinger Health Systems in Danville, Pa., and **Community Medical Center** in Scranton, Pa., are planning to merge. Geisinger also received final approval from Pennsylvania's Department of Health and Attorney General on its merger with **Shamokin Area Community Hospital** in Coal Township, Pa.

A subsidiary of Naples, Fla.-based **Health Management Associates** has signed a definitive agreement to acquire Knoxville, Tenn.-based **Mercy Health Partners**, a subsidiary of Cincinnati-based **Catholic Health Partners**.

Highmark plans to acquire Pittsburgh-based **West Penn Allegheny Health System** for approximately $500 million.

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 three groups first tried to discuss a new affiliation agreement in 2007, but negotiations became contentious over how other hospitals in Kansas City could use the "KU Cancer Center" brand.

Maywood, Ill.-based **Loyola University Health System** is officially part of Novi, Mich.-based **Trinity Health**. Under the consolidation agreement, Trinity Health is the owner of LUHS, while the Stritch School of Medicine, Marcella Niehoff School of Nursing and other programs will continue to operate as part of Loyola University Chicago.

The board of directors at Henderson, N.C.-based **Maria Parham Medical Center** and **Duke LifePoint Healthcare** have signed an agreement to jointly own and operate MPMC.

Georgia Attorney General Sam Olens has approved Albany, Ga.-based **Phoebe Putney Health System**'s acquisition of **Dorminy Medical Center** in Fitzgerald, Ga., despite the fact Phoebe Putney is engaged in a lawsuit over purchasing Albany, Ga.-based **Palmyra Medical Center**. Mr. Olens previously joined the Federal Trade Commission in a civil action to block Phoebe from buying Palmyra, a $195 million purchase that is currently stalled.

Fort Collins, Colo.-based **Poudre Valley Health System** and the **University of Colorado Hospital** at the Anschutz Medical Campus in Aurora have signed a letter of intent to create a joint operating agreement.

Prime Healthcare Services Foundation, the non-profit arm of Ontario, Calif.-based **Prime Healthcare Services**, plans to acquire bankrupt **Victor Valley Community Hospital** in Victorville, Calif., for $35 million.

Mokena-Ill.-based **Provena Health** and Chicago-based **Resurrection Health Care** have signed a deal to merge. The merger, which was explored in February, will create the largest Catholic-owned healthcare system in Illinois and nearly $3 billion in operating revenue.

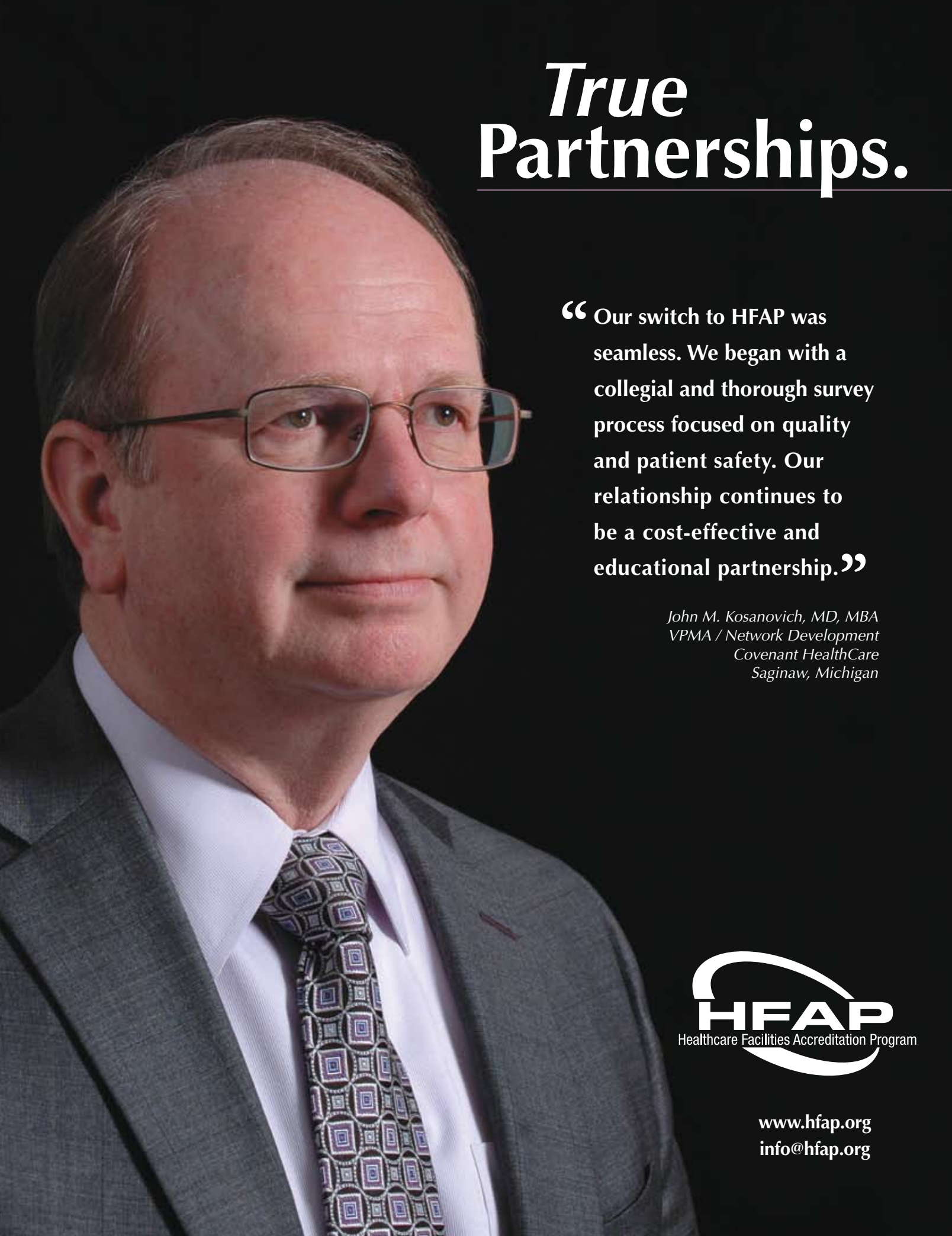
Quincy (Mass.) Medical Center filed for Chapter 11 bankruptcy protection as a part of its acquisition by Boston-based **Steward Health Care**. Steward's acquisition of Quincy must also gain multiple regulatory approvals before proceeding, a process which may take several months.

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

Upstate Medical University Hospital in Syracuse, N.Y., will officially assume ownership and operations of **Community General Hospital**, also in Syracuse. CGH will be renamed **Upstate University Hospital at Community General**.

Westview Medical Campus in Indianapolis has formally affiliated with Indianapolis-based **Community Health Network**.

Wheaton (Minn.) Community Hospital and Medical Center and Fargo, N.D.-based **Sanford Health** have officially merged, changing the hospital's name to the **Sanford Wheaton Medical Center**.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Hospital & Health System Executive Moves

Eric Beyer was chosen to lead as the next president and CEO of Tufts Medical Center in Boston and will succeed outgoing President and CEO Ellen Zane, who is retiring.

Anthony Cooper was appointed president and CEO of newly formed Arnot Health after its certificate of need application to consolidate Arnot Ogden Medical Center and St. Joseph's Hospital, both in Elmira, N.Y., was approved. The hospitals moved forward to create Arnot Health with Ira Davenport Memorial Hospital in Bath, N.Y.

Steven Corwin, MD, was appointed CEO of New York-Presbyterian Hospital in New York City. Simultaneously, **Robert E. Kelly**, MD, was named president of New York-Presbyterian.

Paul DellaRocco, CEO of Franciscan Children's Hospital in Boston, was removed from his post by the hospital board for allegedly inappropriately billing the hospital for expenses.

Ronald J. Del Mauro, CEO of Saint Barnabas Health Care System in West Orange, N.J. since its inception in 1996, announced his plan to retire at the end of this year.

Christiana Care Health System in Wilmington, Del., chose **Patrick Grusenmeyer** to lead as president of Christiana Care Health Initiatives, which includes the Glasgow Medical Center and Delaware Sleep Centers.

Michael Gustafson, MD, was appointed to lead Boston's Faulkner Hospital as COO. He most recently served as senior vice president for clinical excellence at Brigham and Women's Hospital and Faulkner Hospital.

The board of directors at Spartanburg (S.C.) Regional Healthcare System named **Bruce Holstien** president and CEO.

Steven P. Johnson was selected to be the new president and CEO of Health First in Rockledge, Fla., and will be replacing Michael Means, who will retire at the end of 2011.

Jeffrey Korsmo was appointed the new president and CEO of Via Christi Health System based in Wichita, Kan. He joins the health system from The Mayo Clinic.

Ed Noseworthy, CEO of 112-bed Bert Fish Medical Center in New Smyrna Beach, Fla., left his post to become CEO of 139-bed Florida Hospital Fish Memorial in Orange City.

After Highmark acquired West Penn Allegheny Health System in Pittsburgh, it was announced that **Christopher Olivia**, MD, president and CEO of WPAHS, will step down from his role.

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

Jim Sanger, president and CEO of SSM Health Care-St. Louis and regional president/system vice president for SSM Health Care, will retire at the end of this year.

Miami-based Jackson Health System named **Don Steigman** COO. Mr. Steigman most recently served as CEO of Auditz, a company that provides software services to hospitals.

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 will take over as president and CEO of St. Louis-based SSM Health Care and will succeed current CEO Sister Mary Jean Ryan, who will transition to SSM Board Chair.

Thomas Tulisiak, MD, was appointed president of Cleveland Clinic's Medina (Ohio) Hospital. He succeeds former President Rob Stall's following his promotion to chief of operations for Cleveland Clinic's regional hospitals.

Beaumont Health System, which has locations in Michigan's Oakland, Macomb and Wayne counties, named **Nick Vitale** executive vice president and CFO.

Robin D. Wittenstein, acting president and CEO of the University Hospital at the University of Medicine and Dentistry of New Jersey in Newark, was appointed the COO and director of Penn State Hershey (Pa.) Health System.

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