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BECKER'S

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

September/October 2012 • Vol. 2012 No. 7

Has Healthcare Reform Brought the End to "Hospital Systems?"

By Molly Gamble

Many healthcare providers don't want to be known as "hospital systems" anymore. Some hospitals and health systems are taking reform into their own hands by redefining their brand, mission and business strategies to better reflect the contemporary broader values of healthcare reform. The phrase "hospital system" connotes a sense of limitation and constraint in today's healthcare environment, in which successful systems are expected to include surgery centers, physician groups, home health agencies, rehabilitation facilities and sometimes even health plans.

continued on page 9

6 Trends in an Era of Consumer-Driven Healthcare

By Bob Spoerl

Beginning with high-deductible health plans and cost sharing models, which started springing up around a decade ago, and continuing to the creation of health insurance exchanges — written into the Patient Protection and Affordable Care Act — consumerism has been on a steady rise in the healthcare industry.

More and more hospitals and physicians are taking note and tweaking the way they provide care to appease these better informed patients.

continued on page 10

5 Observations on the State of Hospital Credit Markets

By Bob Herman

The credit and debt markets have been markedly different since 2008, when the United States and much of the world officially entered a financial crisis that impacted the credit of almost every borrower.

Hospitals and other healthcare borrowers are no strangers to the evolving credit markets. Everything from the Eurozone crisis to the Libor scandal to the continuing, sluggish economy in the United States has had a direct or indirect impact on hospitals, their investments and their ability to borrow.

Here are five observations on the current state of the hospital credit markets.

1. Interest rates are historically low, leading to a favorable market. The federal funds effective rate has held around 0.16 percent in the past several months — a historically low interest rate for general borrowing, as the federal government continues to try to stimulate the economy.

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Barbara Martin, President and Chief Executive Officer, Vista Health



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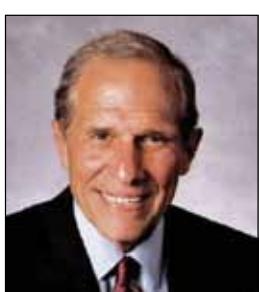
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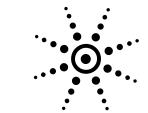
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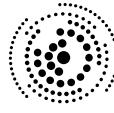
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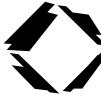
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Becker's Hospital Review

Publisher's Letter

Becker's Hospital Review Special Lists Issue; CEO Strategy Roundtable; 2013 Annual Meeting

September/October Issue. We are pleased to share with you the September/October issue of *Becker's Hospital Review*. This "Lists Issue" features listings of the largest for-profit and non-profit hospitals and health systems in the country, as well as listings of the country's top-grossing hospitals. It also includes two of our popular annual lists, "300 Hospital and Health System Leaders" and "100 Great Community Hospitals." Also included in this issue are Q&As with two leading hospital executives: Carlos Migoya, CEO of Jackson Health System in Miami, and Dr. Gary Kaplan, CEO of Virginia Mason Medical Center in Seattle. Both share their insight on challenges facing their organizations and opportunities ahead for healthcare delivery.

CEO Strategy Roundtable. The *Becker's Hospital Review* Annual CEO Strategy Roundtable will be held Nov. 1, 2012, at the Ritz-Carlton Chicago. Twelve CEOs from leading hospitals and health systems around the country will participate in the discussion, including Charles Martin of Vanguard Health Systems, Dean Harrison of Northwestern Memorial Hospital in Chicago, Bill Leaver of Iowa Health System and David Brooks of Providence Regional Medical Center Everett, among others. The event will be co-chaired by myself and Chuck Lauer, former publisher of *Modern Healthcare*.

Sessions will be held from 4 to 6 p.m. and will be followed by a networking dinner. For more information or if you are interested in attending, contact Jessica Cole at jcole@beckershospitalreview.com. Only 50 registration spots remain.

2013 Annual Meeting. Please save the date for our 2013 *Becker's Hospital Review* Annual Meeting, May 9-11, 2013, at the Westin Michigan Avenue in Chicago. The event will feature leading hospital and health system CEO and CFO speakers and will include roundtables of CEOs and CFOs from systems across the country discussing current opportunities, challenges and strategies for hospitals.

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

Very truly yours,

Scott Becker

Becker's Hospital Review Annual Chief Executive Officer Strategy Roundtable

November 1st • Chicago

Please join us for the Becker's Hospital Review Annual Chief Executive Officer Strategy Roundtable from 4 - 6 p.m. on November 1st at the Ritz Carlton in Chicago. Dinner and a reception to follow. Come listen to 12 panelists discuss their biggest concerns and how they are addressing them. The panelists include:

- | | | |
|---|---|--|
| 1. Larry Anderson , CEO, Tri-City Medical Center | 5. Steve Goldstein , President and CEO, Strong Memorial Hospital | 9. Charles Martin , Chairman and CEO, Vanguard Health Systems |
| 2. Dave Brooks , CEO, Providence Regional Medical Center Everett | 6. Dean Harrison , President and CEO, Northwestern Memorial HealthCare | 10. Megan Perry , President, Sentara Potomac Hospital |
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Has Healthcare Reform Brought the End to "Hospital Systems?" (continued from page 1)

"The challenge for most organizations is they still think they're in the hospital business," says Casey Nolan, managing director at Navigant Health in Washington, D.C., and leader of the firm's healthcare strategic planning practice. "That's the reason railroads got into trouble years ago. They thought they were in the railroad business, not in the transportation business."

Railroads experienced a golden age for about 40 years until cars, airplanes and other forms of transportation began to take over. The railroad industry didn't redefine itself fervently enough, which led to hard times. "Hospitals need to realize they're not in the hospital business, they're in the care coordination business," says Mr. Nolan.

Healthcare reform requires a gradual change, especially with the red tape of federal rules and regulations. Some hospital and health system leaders are choosing to take the reigns *now*, however. They are redirecting their organizations to focus on different success factors than they did five, 10 years ago.

"Most people would agree that the costs of healthcare are unsustainable. But in the absence of immediate, massive reform, there has to be *something* someone can do to start making a difference. Approaching healthcare from the broader perspective of health and wellness is a tactic hospitals and health systems can implement now," says Marion Crawford, president of Greenville, S.C.-based Crawford Strategy.

A new business strategy can take several years to complete, Mr. Nolan says, and timing is critical. An organization doesn't want to redefine its strategy as a health system too early or too late. These are the challenges of operating in an industry that is half fee-for-service, half pay-for-performance. "You'll have to be a little schizophrenic for a few years. The transformation will take several years, and the timing is very important," he says.

Missions, visions and values — some can change while one stays the same

Three of the most visible avenues for a hospital system to redefine itself are through its mission, vision and values. These anchor an organization's identity, but some are more change-friendly than others. In fact, most of today's hospitals and health systems are redefining themselves and their place in the community without altering their mission statements, which tend to remain invariable throughout the hospital's lifetime. A change in name, adoption of a new payment model, facility expansion — even a change in business strategy — rarely require a change of organizational mission.

"There are three bedrock things [comprising] an organization's strategy: mission, vision and values," says Mr. Nolan. "The mission statement is really the organization's reason for existence. That very seldom, if ever, changes. The vision may change, and business strategies may change, but missions are pretty near to being carved in stone," he said.

Mission statements usually describe tasks that can't be measured or complete, and this ongoing nature of the statement makes it less subject to change. For instance, Rochester, Minn.-based Mayo Clinic's mission is, "To inspire hope and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research." Rush University Medical Center's mission statement is, "To provide the very best care for our patients. Our education and research endeavors, community service programs and relationships with other hospitals are dedicated to enhancing excellence in patient care for the diverse communities of the Chicago area, now and in the future."

Visions and values, on the other hand, can be altered throughout the organization's lifetime to keep the organization abreast with issues in the community. "The vision can, and should, change pretty regularly. While you can never complete the mission, the vision is what you want to become

or achieve. 'We want to make our community the healthiest in the United States.' You can measure that. You can accomplish that," says Mr. Nolan.

Trying to change how and when people think of hospitals

Health systems not only want to change *how* they are perceived by patients, but *when* people think about visiting a health system facility. Many are trying to move away from the traditional understanding that hospitals are for the sick. Instead, they want to instill the idea of hospitals as places of health maintenance. One way an organization can emphasize this renewed focus is through a name change. These days, that name change might involve the addition or omission of only one word.

Orange, Calif.-based St. Joseph Health System made a slight adjustment to its name in May when it dropped "System" from the title. The 14-hospital network says the adjusted name reflects its broader goals. St. Joseph Health's subsidiary, Lubbock, Texas-based Covenant Health System, also dropped the last word of its title to become Covenant Health. The parent system began considering this transformation in 2006, well before the Patient Protection and Affordable Care Act. It developed a plan to foster broad networks of care — "not just hospitals for treating the ill or injured," according to St. Joseph Health President and CEO Deborah Proctor.

Devising the organization's new business strategy extended beyond internal stakeholders, and St. Joseph chose to emphasize collaboration in its redefined identity: "During the past 18 months, we have received input from thousands of stakeholders — including employees, physicians, board members and a variety of community members — who are committed to our vision of bringing people together to provide compassionate care, promote health improvement and create healthy communities."

"In my role as president and CEO, I am charged with creating an environment to make this vision a reality," says Ms. Proctor. "Our strategy calls for us to recognize that we should not face our future alone. We must build new partnerships and seek like-minded partners that help us provide a continuum of care for our communities."

Ms. Crawford has helped hospitals communicate new business strategies and visions. One relatively small regional hospital she worked with undertook a complete rebrand in order to better reflect their new approach to health. "Not only did they want to embrace health clinically, but they recognized that they needed to embrace wellness and life in their marketing throughout the community. As a part of their new plan, all marketing campaigns emphasized 'X Health' rather than 'X Hospital.' The hospital system's leaders wanted people to think of them before they got sick."

This particular hospital also revised its vision as part of its rebranding campaign. The new vision emphasized partnerships, the promotion of individual health and vibrant communities — three contemporary values that underscore the major principles of healthcare reform.

Still, it's not entirely a matter of "out with the old, in with the new." Hospitals should not go too far in rebranding efforts, or they may mistakenly reach a point of alienating the community and patients. The goal isn't to abandon the purpose of caring for the sick; it's to emphasize the broader values of American hospitals. "The role of a hospital is still to care for the sick, but that there is also a very valid role in promoting health and wellness initiatives," says Ms. Crawford.

If missions don't change, what do they do?

A hospital website is not the only place a hospital's mission should "go live" — it should be the pulse of the organization, starting with the C-suite. It should be second nature for healthcare leaders to base decisions, ideas and strategies on the mission, says Kathleen E. Kuck, president and CEO of Pocono Health System in East Stroudsburg, Pa. Those decisions are subject to change over time as organizations grow and evolve, but their agreement with the organization's mission serves as the deciding factor.

Ms. Kuck often asks herself a series of questions to remain acquainted with the mission of Pocono Health System. "As leaders, [the mission] should become so routine that we begin and end every meeting with a reaffirmation of our commitment to our mission. It should be the first question that is habitually asked at every decision point: Is it consistent with our mission? Does it support our mission? Will it enhance our mission? Does it live our mission?"

Mission statements differentiate one hospital from another in any given market, but leadership shouldn't confuse them with taglines. This can be a dangerous misunderstanding. Dan Pallotta, a writer for *Harvard Business Review*, has scrutinized organizations' mission statements across all industries and has forewarned leaders that missions run the risk of becoming public relations gimmicks.

"The commitment is the source of the mission. The statements are merely the byproduct of the commitment. A mission statement can't create a commitment. And a commitment can't be thwarted by lack of a mission statement," Mr. Pallotta wrote in a January 2011 *HBR* blog post. "Nelson Mandela didn't have a mission statement for creating a free South Africa. But man, was he on a mission."

Merged organizations need to ask one question of themselves

One of the few external circumstances that requires change to a hospital's identity and mission is a transaction. This tends to be less of an issue when one hospital buys another one, since the latter typically adopts the buyer's values, vision and mission. Mergers, however, call for new thinking. As hospital consolidation continues to climb, there is likely to be a wave of new trends and values in hospital missions.

"When you're truly doing a merger and creating a new organization, you have to establish a new mission statement," says Mr. Nolan. This seemingly daunting task can only take a few hours of focused team leadership,

primarily focused around one question: Why do we exist?

"We ask that question four or five times. Then you can boil the answer down to why an organization truly exists," says Mr. Nolan. The point is to find a mission that resonates internally with the organization, and to keep those ideas short, concise and easy to understand. Healthcare reform has also unleashed a new lexicon of healthcare values, and many of those terms and ideas are likely to be more prominent in merged systems' identities.

For instance, some of these key values can be found in the mission statement of St. Peter's Health Partners. The system formed in 2011 through the merger of St. Peter's Health Care Services in Albany, N.Y., with Troy, N.Y.-based Northeast Health and Seton Health. Leaders from the three organizations crafted the following mission: "Founded in community-based legacies of compassionate healing, we provide the highest quality comprehensive continuum of integrated health care, supportive housing and community services, especially for the needy and vulnerable." The organization's name and logo of three interlocked geometrical shapes was carefully crafted to emphasize collaboration and partnership, and the word "system" was noticeably left out of its name.

It all starts with one decision

The creation of new business strategies or organizational values is no small task — it involves multiple stakeholders, community input, a financial outlay and a considerable amount of communication and marketing savvy. Still, despite this involved and complicated process, the decision to propel an organization forward in a reformed healthcare industry begins with a simple realization that a different approach is necessary.

"Sometimes it's the hospital system that organizes everyone, other times it's a governmental body," says Ms. Crawford. "But it takes somebody to say, 'You and you and you should all join forces for the broader objective of creating a healthier community — together.'"

6 Trends in an Era of Consumer-Driven Healthcare (continued from page 1)

Websites and mobile apps are making it easier for patients to get more healthcare information, as HHS, private companies and some payors are helping distribute cost and quality of care data.

There are a number of trends stemming from a shift toward consumer-driven healthcare. Hospitals that ride the waves of these changes may be in a better position to stay financially sustainable in an era when competitive pricing and patient satisfaction can make or break a hospital's chances of succeeding.

Here are several trends causing a rise in consumer-driven healthcare.

1. Legislation is providing health consumers with more options and transparency. The rise of consumerism in healthcare "will increase dramatically with the creation of healthcare exchanges," says Doug Fenstermaker, managing director and vice president of healthcare consulting firm Warbird Consulting Partners. State-regulated health insurance exchanges, which kick in beginning 2014 if the Supreme Court upholds the healthcare law, "are essentially virtual healthcare menus," Mr. Fen-

stermaker says. The insurance exchange will set side-by-side various insurance premiums, out-of-pocket co-pays and direct payments to providers in a way that is more transparent for the healthcare consumer.

Further, should employers choose to provide defined contribution instead of defined benefit healthcare plans, consumers will likely shop around for better-valued health plans. "More employers will not be able to continue to pay the shift of cost to them from uncompensated care borne by hospitals and doctors," he says. And if the Supreme Court strikes down the individual mandate provision of the PPACA, Mr. Fenstermaker predicts an increase in the number of consumers who price shop.

Another element of a more consumer-driven healthcare era is a push toward greater transparency in costs. A bipartisan Texas tag team of congressmen, Reps. Michael Burgess, MD, (R) and Gene Green (D), recently introduced legislation that would require hospitals to disclose the cost of inpatient and outpatient services.

The Health Care Price Transparency Promotion Act of 2012 would mandate that states establish laws requiring hospitals to disclose charges for both inpatient and outpatient services. Additionally, health insurers would need to provide

enrollees in a health plan an estimated out-of-pocket cost for healthcare items and services.

The legislation also asks the Agency for Healthcare Research and Quality to study the type of healthcare cost information consumers find most useful, part of an effort to provide consumers with simple and timely healthcare cost information.

2. Private companies and payors are also promoting cost of care transparency. While HHS already publishes information about insurance plans and allows consumers to compare providers based on quality, safety and patient satisfaction indicators at Healthcare.gov and other websites such as Hospitalcompare.hhs.gov, private companies such as San Francisco-based Castlight Health are getting into the game of publishing provider information, including paid claims data. Castlight says it uses algorithms and proprietary technology along with data analytics to drill down and publish cost of care information it then sells to companies that, in turn, provide employees with that data.

Consumers are looking for more transparency in part because they are paying more out-of-pocket for procedures, but also out of frustration with how hospital bills are calculated. As noted in a recent *New York Times* article, the cost of care

can vary widely for the same procedure from hospital to hospital, or even, in some cases, at the same hospital. The example used in the report is a routine appendectomy, which costs anywhere from \$1,500 in California to, in one case, more than \$182,000.

Moreover, many consumers are unaware of how much medical treatment is supposed to cost.

"The problem individuals are facing," says Peter Isaacson, chief marketing officer of Castlight, is that "they are taking on expenses without the tools to help them really make informed decisions and understand the tradeoff that might exist between cost and quality."

Some health insurers are also publishing cost of care data in an effort to help patients make more informed healthcare decisions. For example, United Healthcare and Blue Cross have widgets that predict out-of-pocket costs based on a customer's policy design and whether they've met their deductible.

3. It's still unclear how many consumers are using online and mobile cost of care tools. While websites such as those run by the government and private organiza-

tions, such as HealthGrades.com, publish benchmarking data on hospitals and physicians meant to inform patients about quality of care, the question is whether patients actually use the online tools available to them.

"While HealthGrades has been around for many years, consumers' use of tools is still a pioneering activity," says Jane Sarasohn-Kahn, MA, MHSA, a health economist and blogger. "Healthcare report cards have also been available, but most consumers still spend more time researching buying a new car or washing machine than they do comparing health plans. Therefore, we don't know yet whether the tools pay off."

A regional example in Utah shows that some consumers are using cost of care and quality data to make healthcare decisions. Regence Blue Cross Blue Shield in Utah recently surveyed 13,000 users and found that 28 percent changed providers based on cost information and quality data made available online, according to a recent article in *The Salt Lake Tribune*.

In an era when consumers pay more for their health and healthcare organizations are forming accountable care models with built-in payment incentives for driving down costs, it's becoming

increasingly important for both providers and patients to have an understanding of the type of care needed and how much that care costs.

"We need to have patients prove their health literacy in a more dramatic way," says West Shell II, chairman and CEO of Healthline, a San Francisco-based company that provides health information to consumers. "They need to be empowered to make the right decisions."

For consumer-driven healthcare to work, employers and individuals purchasing care need to have a firmer grasp of healthcare literacy, Gail R. Wilensky, the former director of CMS and a senior fellow at Project HOPE, writes in an Atlantic editorial.

"Consumers and patients need to become more involved in their own health — they need to know their plan options and what they cost, have a reason to care, and be rewarded to adopt healthier lifestyles," Ms. Wilensky writes. "That would be a very different world from the one we've been living in."

Here are some of the effects of the rise in consumerism and ways hospitals and physicians might further adapt in a consumer-driven healthcare era.

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4. As healthcare costs shift to consumers, hospitals can help provide more consumer-driven care. The rise in the early 2000s of health savings accounts and consumer-driven health plans — or high-deductible plans — was a way for consumers to “get more skin in the game,” says Ms. Sarasohn-Kahn. But she says high-deductible plans haven’t necessarily helped consumers become more savvy healthcare decision-makers.

“What we have seen in the first few years with consumer directed health plans is that people aren’t using them wisely. People will make what they think are smart fiscal decisions which lead to bad long-term physical consequences,” she says.

However, an influx of online tools and mobile apps means patients have less of an excuse to be in the dark about their healthcare costs.

“Utilizing price comparison tools, patients now can understand the financial implications of their care decisions, more credibly request discounts from high-cost providers, and direct themselves towards more affordable providers,” says Adam C. Powell, PhD and President of Payer+Provider Syndicate, a healthcare consulting company.

In order to survive in a consumer-driven era, hospitals will need to provide transparency on price, quality and services as well as deliver a high level of customer service, thinking more along the lines of a retail store like Nordstrom’s than a health provider, Ms. Sarasohn-Kahn says.

Hospitals can help the growing number of patients paying more out-of-pocket for care by embracing consumer-driven healthcare and actively promoting it. In turn, hospitals will be helping themselves.

“Hospitals are much-trusted players in consumers’ local health markets,” Ms. Sarasohn-Kahn says. “They have the opportunity to leverage that trust

in the consumer era by becoming more retail-oriented. The trend of many hospitals providing more wellness and fitness services, along with partnering with after-hours care providers, such as retail and work-site clinics, are signposts on the road toward more retail health,” she says.

Proactive hospitals that respond to the call of the consumer may be in the best position to survive, no matter the next turn healthcare reform takes.

5. Hospitals are already striving to promote themselves to more consumer-minded patients. “Today’s hospitals are just as aggressive about advertising and promoting their services to potential customers as any other vendor,” says Mario Almonte of Herman & Almonte PR, a New York-based agency specializing in healthcare communications. “Beyond getting the customer to their beds, they are also finding ways to ‘keep the customer for life’ through ongoing campaigns to sell additional services to them.”

The fact that hospitals are seeking to make more intimate connections with patients and treating them as consumers is not a new phenomenon. But now, in an era when mobile access and social media brings a sense of hyper-connectivity to life, the trend may seem more pronounced than ever before.

Rhoda Weiss, PhD, a national healthcare consultant, speaker, author and editor of Marketing Health Services Magazine, emphasizes the importance of hospitals creating a recognizable brand for their patient audience. She suggests hospitals create professional and engaging videos to post on YouTube and other social media sites that tell a patient’s story. Dr. Weiss says it’s about creating memorable experiences at hospitals: striving for strong first impressions, short waits, attention to detail when communicating with patients and making patients laugh when appropriate.

“You don’t need a big budget to do marketing — you can have a smaller budget and still reach your brand positioning and marketing goals,” Dr. Weiss said at the Becker’s Hospital review conference in May. “Because marketing is about relationships.”

Building that relationship is a proactive step toward increasing patient satisfaction and keeping a hospital’s credibility high. Also, improving patient satisfaction can help a hospital build a strong word-of-mouth reputation, which may be an underestimated part of a hospital’s success in a consumer-driven healthcare era.

6. Hospitals and physicians with a focus on prevention to curb patient healthcare costs may promote that to consumers. Moving forward, hospitals might leverage strong population health management skills to advertise to the consumer-driven patient. By identifying target health concerns in a population, health systems and hospitals are potentially less at risk of dropping the ball on patient care, at least on a macro-level.

“With a solid population health management program, hospitals can make a positive and significant impact on the health of the entire community while creating a stronger and more financially sound healthcare organization,” says Pearson Talbert, president and CEO of Nashville, Tenn.-based hospital consulting firm Aegis Health Group.

Physicians have skin in the game too. Accountable care organizations and other integrated care models are providing physician groups financial incentives to improve patient outcomes. In the not so distant future, as many as half of a physicians’ earnings may be based on quality outcomes, according to CEO of Objective Health Russ Richmond, MD. With incentives to improve long-term health of patients, primary care physicians are spending more time on preventative care. But for patients to participate fully in preventative measures they need to be engaging and incentive-based, says Ms. Sarasohn-Kahn.

“You have to create in connected health systems incentives for patients to connect back,” she says. “You want to enable patient engagement, which requires interactive tools, carrots, and when appropriate, sticks.” ■

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10 Considerations for Hospitals in the Aftermath of Supreme Court's PPACA Decision

By Bob Spoerl

The Supreme Court made a historic decision on June 28 to uphold the Patient Protection and Affordable Care Act. The Court let the individual mandate stand, via Congress' power to tax, but limited lawmakers' ability to withhold funding from states that choose to opt-out of Medicaid expansion.

Healthcare leaders' reactions were mixed. Some leaders embraced healthcare reform's constitutional affirmation; President and CEO of the American Hospital Association Rich Umbdenstock said in a statement the Court's decision to uphold the law provides hospitals with "much-needed clarity to continue on their path toward transformation."

Other healthcare leaders were more lukewarm in their response to the Court's decision. John R. Tongue, MD, president of the American Association of Orthopaedic Surgeons, cautioned providers not to overlook the "administrative burdens within the law that could greatly hinder providers' ability to deliver quality care by infringing upon exam room time."

Regardless of their opinion on the ruling, many hospital leaders are seriously discerning the consequences of it. Here are ten considerations for hospitals given the Court's ruling and ongoing issues with the nation's healthcare system.

1. Plan for an increase in insured patients. One of the selling points of the landmark 2010 healthcare law was a promise to increase coverage for millions of more Americans. Through Medicaid expansion and federal subsidies for health insurance exchanges — online marketplaces where individuals and small business can purchase private health plans — the PPACA funds insurance opportunities for people who previously went without. Thus, hospitals should continue to prepare for more patients with coverage. With millions more patients gaining access to preventive care, the idea is for emergency rooms to be less crowded and for patient throughput to improve.

Initially, an estimated 30 more million Americans were expected to have new coverage by

2014; however, that number has since decreased because of the Supreme Court's decision to allow states to opt-out of whether they want to expand Medicaid coverage to adults who make less than 133 percent above the poverty line, around \$31,000 for a family of four.

2. On Medicaid expansion, know where your state stands. If states decide to not take more money from the federal government to expand Medicaid coverage, they may be left with hundreds of thousands of uncovered individuals. And that would mean hospitals and health systems would not receive the added reimbursements anticipated from the Medicaid expansion in their state.

"For providers, this calls into question the potential success of the PPACA's intent to eliminate a large chunk of the uninsured — some 16 million Americans," says healthcare attorney Susan Feigin Harris, JD, a partner in the Baker Hostetler Healthcare Practice Group. "If a provider's state chooses to forgo the expansion, a provider could still be faced with significant numbers of uninsured patients and experience Medicaid payment shortfalls."

The best bet is for hospitals to assess what the Medicaid expansion will mean in their individual state. Some conservative states may decide to opt-out of Medicaid expansion, even though funding called for in the PPACA pays in full for the first few years of states' Medicaid expansions. Republican governors in Louisiana, Texas and other states have already vowed to refuse PPACA funding for Medicaid expansion.

"Indeed, in the 26 states that participated in the federal lawsuit, more than 27 million people have no insurance and many who would have been eligible for Medicaid in 2014 might no longer have that option," says Bruce Siegel, MD, MPH, CEO and president of the National Association of Public Hospitals and Health Systems.

3. Safety net hospitals should prepare for potential Medicaid shortfalls. Anticipating a rise in the number of lower income Americans insured, the PPACA included cuts to

disproportionate share hospital funding. Those cuts could be from 25 percent to 50 percent reductions in federal money beginning in 2014.

Safety net hospitals need to prepare for Medicaid cuts. In states that may choose to opt-out of Medicaid expansion, the issue may be more severe.

The hospital industry, in a sense, struck a deal on provider cuts during the drafting of the healthcare law and accepted DSH cuts because it thought the country as a whole would deal with the issue of large number of uninsured. "There are a lot of components in our healthcare system that are extremely important and feeding each other, and there's a domino effect if we take away money from safety net hospitals," Ms. Harris says.

Ms. Harris, who counsels a number of children's hospitals, says that many hospital advocates are trying to bring solutions both at the state and federal legislative level. She adds that, on the federal level, the HHS secretary has a fair amount of discretion in how DSH cuts are dispersed, but that, as with everything, the devil is in the details.

She says executives at DSHs and other hospital leaders have important questions to ask, including:

- If your state will not expand Medicaid, how much pressure will your hospital or system bring to bear on the state legislature to potentially change the position of the governor?
- Do you have any impact with respect to DSH reductions? How can you make the argument that in a state without expansion you should not have reductions?
- What impact will belt tightening in both state and federal government budgets have on provider rate cuts?

The National Association of Public Hospitals and Health Systems has already begun meeting with the White House to discuss what to do about the Medicaid expansion-DSH dilemma.

"We've expressed our concerns to the administration about the looming DSH cuts and asked that

the agency's formula for allocating the cuts across states recognize the changing landscape of Medicaid expansion," Dr. Siegel says. "We believe states should target DSH support to the patients and hospitals in greatest need."

4. Cut hospital waste and inefficiency. The call for healthcare reform that brought about the PPACA stems from a trend of rising healthcare costs dating back more than a decade. While healthcare spending nationwide has increased by a less rapid rate over the last two years compared to before the PPACA, healthcare spending is still more than 18 percent of the nation's gross domestic product, and continues to climb. Cutting unnecessary procedures at hospitals or inefficient administrative processes, along with reducing readmissions, are several examples of ways to reduce the rising cost of care.

"Healthcare costs are high and growing too rapidly, and we must become more efficient," says Ronald A. Paulus, MD, the CEO of Mission Health in Asheville, N.C.

John Toussaint, MD, CEO emeritus of ThedaCare and CEO of the ThedaCare Center for Healthcare Value in Appleton, Wis., says there are three important components of true health reform, two of which were addressed by the PPACA: payment reform and the release of Medicare data to patients.

"The third component is the redesign of healthcare delivery to remove waste and improve quality," he says. "With falling revenues healthcare delivery organizations will have little choice but to become more efficient."

ThedaCare implements a Lean health model that has helped the health system save millions of dollars over time. Hospitals such as Virginia Mason Medical Center in Seattle have implemented similar Lean management styles that borrow from a production system made popular by car manufacturer Toyota. The theory is to weed out inefficient processes at every step of the way, thereby providing a lean, highly valuable end product.

5. Prepare for new healthcare delivery and payment models.

Some providers may have been playing the waiting game to see how the Supreme Court would rule on the PPACA before implementing major changes. But the waiting game is over, and many hospitals and health systems are preparing for changes ahead. Many were doing so long before the Court's decision to uphold the healthcare law.

"We are pleased that there is now clarity on the constitutionality of the law," says Dr. Paulus. "However, it's important to note that with or without reform the overarching issues are the same."

Dr. Paulus sees four main issues that hospitals, as an integral part of the healthcare system, will need to address moving forward:

- Inadequate care quality nationally;
- Soaring healthcare costs;
- Too many uninsured or underinsured individuals; and
- Inappropriate incentives "hard-wired" into the system that reward for "more" rather than best outcomes.

Getting to the bottom of systemic healthcare issues was the impetus for the landmark 2010 healthcare law. It contains billions of dollars of funding cuts to providers spread over a decade in exchange for millions of newly insured Americans. The PPACA also encourages value through CMS' Hospital Value-Based Purchasing Program that awards acute-care hospitals for improving quality of care for Medicare patients and funds several programs to test new payment models, such as the Medicare Shared Savings Project and Bundled Payments for Care Improvement.

Some hospitals and health systems started adapting before the Supreme Court ruling and are continuing to advance new care and payment models, including patient-centered medical homes, bundled payment models and

accountable care organizations. Private payors, including Aetna, Blue Cross Blue Shield and Cigna, are embracing ACO ventures with hospitals and physician groups. Cigna hopes to set up 100 accountable care initiatives — Cigna's version of ACOs — by the end of 2014.

Other hospitals decided to take a wait and see attitude to hospital reform following the signing of the 2010 healthcare law. However, the waiting game may be ending.

"Those systems are getting off the sidelines," says Sanjay Saxena, MD, partner in Booz & Company's North American Health Practice. "I think all systems are moving forward on health reforms because it's really hard to be a system stuck in the middle anymore."

As payment models shift, more physicians are entering into hospital employment or closer alignment structures with health systems. A recent Merritt Hawkins survey on physician employment predicts that as many as 75 percent of newly hired physicians will be hospital employees by 2015.

6. Evaluate your hospital's ability to take on new risks. Hospitals are entering into new relationships with payors, patients and the government as a result of healthcare reform. They are accepting more risk and responsibility for the outcome of the care they provide. Some hospitals may be considering Consumer Operated and Oriented Plans, funded by the PPACA. The law defines these CO-OPs as non-profit insurance companies. They are intended to be competitive models to traditional health insurance companies, says William C. Mohlenbrock, MD, the chief medical officer of Verras.

"Hospitals and physicians are consumers and can therefore integrate themselves and form a provider-sponsored CO-OPs," Dr. Mohlenbrock wrote in a recent *Becker's Hospital Review* article.

CO-OPs are meant to produce high-quality care while containing costs. "CO-OPs will facilitate these outcomes by aligning physicians' and hospitals' incentives to improve quality outcomes and share savings — when their utilization of medical resources is appropriate and efficient," Dr. Mohlenbrock adds.

The federal government has allocated \$3.8 billion to provide start-up funding for CO-OPs; organizations need to submit requests to HHS for consideration and applications are being accepted through the end of the year. Starting January 2014, consumers will be able to purchase health insurance from approved CO-OPs. So far, 17 CO-OPs have been awarded \$1.3 billion to plan for implementation.

Some health systems may be looking into offering coverage for patients with the caveat that those patients seek care at hospitals within their system. Boston-based Steward Health Care is doing this with its Community Choice plan. Steward has purchased a number of community-based hospitals, and rolled out a third-party administered health plan in 2011 for small businesses in Massachusetts. Premiums are less, but patients on the plan are limited, by-and-large, to hospitals in Steward's network.

Meanwhile, health plans are continuing to move more aggressively into care delivery. Insurers have set up accountable care arrangements nationwide with hospitals and physician groups. Health plans moving into care delivery will likely continue to include virtual integration as well as joint ventures, and will likely establish future partnerships with larger health systems, according to Dr. Saxena.

7. Embrace health information exchange and health IT solutions. Many hospitals and health systems are already implementing robust health information exchanges that help improve care coordination for patient populations.

The degree of integration between providers in a health information exchange may depend on the amount of ongoing collaboration between them, says Micky Tripathi, CEO and president of the Massachusetts

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eHealth Collaborative. For example, a community hospital in an HIE may not need to have the same level of integration with a regional medical center as it needs to have with a large primary care practice referrer in its own community.

However, improving health information exchange can help small community hospitals and large health systems alike further coordinate care, mitigate risks and, ideally, improve outcomes — all while curbing the cost of care. Coordinating care and trimming rising costs may be the only way for some hospitals to realistically survive.

Ken Perez, director of healthcare policy and senior vice president of marketing at MedeAnalytics, says it's in a hospital's best interest to embrace health information exchange because of payor demands.

"In the new healthcare world, both CMS and commercial payors are going to press for more performance management and not less," Mr. Perez says.

8. Keep close tabs on what happens to the Medicare sustainable growth rate. Besides the many provisions and details in the PPACA, there are several other important legislative issues hospital leaders will likely want to keep on their radar. If Congress does not act by Dec. 31, 2012 to repeal or delay the sustainable growth rate — the formula used to adjust Medicare physician payment rates — physicians will bear a reduction in their Medicare payments that has been variously estimated at 27 to 30.9 percent. This steep cut in Medicare payments could put some medical professionals out of practice.

Every year since 2003, Congress has temporarily bypassed the SGR to ensure there would be no cuts to physician Medicare payments. The current CMS administration wants to repeal the SGR altogether, which would cost more than \$300 billion but eliminate the need for Congress to pass temporary fixes every year.

The American Medical Association and the Medical Group Management Association-American College of Medical Professional Executives have offered several alternatives to the current SGR. Those include rewarding physicians for efficiency and quality, developing new payment models that share savings and training physicians to encourage Medicare beneficiaries to seek high-value healthcare.

"The only problem is that almost everybody who has put forth a legislative solution has failed to present truly credible funding sources for a long-term fix," Mr. Perez says. "The elephant in the room — the problem with reform of Medicare's physician payment system — is figuring out how to fund it. Ninety-five percent of the current conversation is focused on how payment reform should work, but people are not addressing the federal funding issue, which is a huge problem given our nation's worsening debt crisis."

According to the Congressional Budget Office, a 10-year freeze of the current Medicare physician fee schedule rates would cost \$316 billion. Some of the recommendations for long-term Medicare physician payment reform could cost as much as \$400 billion in that time period, according to Mr. Perez.

9. Follow what Congress does regarding sequestration cuts.

Remember the debt ceiling deal from last summer? While it may not be

linked to the PPACA, it's something hospital leaders should watch very closely as the calendar inches toward 2013, according to Mr. Perez.

Included in the Budget Control Act of 2011 is a two percent across-the-board cut to Medicare provider payments, scheduled to kick in January 2013. The Medicare cut will remain at two percent through 2021, while the percentage cuts in other programs will gradually sink, according to the Center on Budget and Policy Priorities.

Hospitals may need to brace for taking a disproportionate share of the sequestration cuts to Medicare, Mr. Perez warns.

"The law doesn't micromanage the cuts down to the level of how to divide the slice of the Medicare pie: It simply says that total Medicare spending will contract by two percent, with the cuts limited to payments to providers, over the next decade," Mr. Perez says. "[The Budget Control Act] does not say the cuts will be distributed equally across physicians, hospitals, long-term care facilities, and other providers."

He said hospitals may be viewed as more monolithic and large, and therefore somehow better able to withstand cuts in Medicare reimbursement. "But the reality is they will feel the financial pain just as much as smaller entities," he says.

10. Know that healthcare reforms could change after the November elections. If GOP candidate Mitt Romney wins the presidency in November and if Republicans gain ground in Congressional elections, there's a chance the Patient Protection and Affordable Care Act would be scrapped through legislative actions in 2013. This may put hospital leaders in a tough position.

"For hospitals, there's revenue to protect and money to be made in pursuing the healthcare delivery reforms in the PPACA," Mr. Perez says. However, he adds that "swirling around this temporary bubble is the potential for legislative repeal."

These three events would need to unfold for Republicans to have a true chance to ax President Obama's landmark health reform law:

- Mitt Romney would need to be elected president.
- Republicans would need at least 50 seats in the Senate, meaning they achieve a net gain of a minimum of three seats in November.
- Republicans would need to retain their majority in the House of Representatives, or have enough Democrats on board for a repeal of the healthcare law.

Because the Supreme Court has called the individual mandate a tax, some contend that Congress could nix certain key provisions of the healthcare law—including the individual mandate, the creation of insurance exchanges, and Medicare and Medicaid funding measures, and possibly others—through budget reconciliation.

"Hospitals should be aware that it is plausible the law could be repealed come January," Mr. Perez says. ■



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300 Hospital and Health System Leaders to Know

Hospital and Health System Leaders to Know

Becker's Hospital Review is pleased to present the following list of "300 Hospital and Health System Leaders to Know." The following men and women have shown admirable dedication to the improvement of healthcare delivery at local, regional and national levels. Some leaders have held their positions for a few months, while others have been at the helm for more than 20 years, but all have demonstrated great promise and skill to the American healthcare landscape.

Editor's note: This list includes members of senior management from a range of hospitals and health systems across the country. Leaders could not and cannot pay for inclusion. Names are arranged alphabetically.

Richard Afable, MD. President and CEO of Hoag Memorial Hospital Presbyterian (Newport Beach, Calif.). Dr. Afable heads the 12th largest hospital in California, with 498 beds. He previously served as executive vice president and CMO of Newtown Square, Pa.-based Catholic Health East.

Nancy Howell Agee. President and CEO of Carilion Medical Center (Roanoke, Va.). Before Ms. Agee assumed her current post in July 2011, she served as Carilion's executive vice president and COO since 2001.

Joel T. Allison. President and CEO of Baylor Health Care System (Dallas). Mr. Allison has led the Baylor Health Care System since 2000. He joined Baylor in 1993 as the senior executive vice president and COO.

Steven M. Altschuler, MD. President and CEO of Children's Hospital of Philadelphia. Dr. Altschuler, a pediatrician, has led CHOP since 2000.

Larry Anderson, JD. CEO of Tri-City Medical Center (Oceanside, Calif.). Mr. Anderson has been CEO of 397-bed Tri-City Medical Center in Oceanside, Calif., since January 2009.

Carl S. Armato. President and CEO of Novant Health (Winston-Salem, N.C.). Mr. Armato has been with Novant since 1998 and was appointed to lead the system in January 2012. Before then, he served as COO.

Timothy Babineau, MD. President and CEO of Lifespan (Providence, R.I.). Dr. Babineau assumed leadership of Lifespan in August 2012. He formerly served as president and CEO of Rhode Island Hospital and The Miriam Hospital, both in Providence.

Robert J. Bachman. CEO of Emory University Hospital and Emory University Orthopaedics & Spine Hospital (Atlanta). Mr. Bachman was named CEO in June 2012. He was formerly COO of the hospital and spine hospital.

Sandra Badinger. CFO of Slidell (La.) Memorial Hospital. Ms. Badinger assumed her post as CFO in July 2012. She came to the hospital from Cypress Pointe Surgical Hospital in Hammond, La., where she served as CFO.

Mark Baker. CEO of Jack Hughston Memorial Hospital (Columbus, Ga.). Mr. Baker assumed his post as CEO in October 2009. Before then, he served as COO of Hughston Clinic in Columbus.

Eric Barber. CEO of Northeast Regional Medical Center (Kirksville, Mo.). Mr. Barber joined Northeast Regional Medical Center as CEO in spring 2010. He has more than a decade's worth of executive healthcare experience, including time spent as COO of Danville (Va.) Regional Medical Center.

Cathy Barr. CEO of Bethesda Hospital (St. Paul, Minn.). Before becoming CEO at Bethesda, Ms. Barr held executive positions at St. Paul, Minn.-based HealthEast as vice president for community-based services and home care senior director.

Brian Baumgardner. CEO of West Florida Hospital (Pensacola). Mr. Baumgardner took over as CEO in July 2012. Since 2008, Mr. Baumgardner served as CEO of HCA's Gulf Coast Medical Center in Panama City, Fla., and prior to that, he was COO of Lawnwood Regional Medical Center in Fort Pierce, Fla.

James K. Beckmann. President and CEO of Carondelet Health Network (Tucson, Ariz.). Mr. Beckmann was named president and CEO in December 2011 after serving as interim leader for two months. Prior to his nine-year tenure with St. Louis-based Ascension Health, he was an insurance executive.

David Bernd. CEO of Sentara Healthcare (Norfolk, Va.). Mr. Bernd has served as CEO of Sentara since 1994. Before then, Mr. Bernd was executive vice president and COO of the system and president of Sentara Hospitals-Norfolk.

Britt Berrett, PhD. President of Texas Health Presbyterian Hospital Dallas. Dr. Berrett has led the 866-bed hospital since February 2010 after serving as president and CEO of Medical City Dallas Hospital for 10 years.

Kenneth Bertka, MD. Vice President of Physician Clinical Integration for Mercy (Toledo, Ohio). Dr. Bertka is a family physician and vice president of physician clinical integration at Mercy, a seven-hospital system that is part of Cincinnati-based Catholic Health Partners.

Michael Blaszyk. CFO of Dignity Health (San Francisco). Mr. Blaszyk is senior executive vice president, chief corporate officer and CFO of Dignity Health, where he oversees financial affairs for the \$13.1 billion integrated healthcare system.

David Blom, CEO of OhioHealth (Columbus). Mr. Blom joined OhioHealth in 1983 and was named president and CEO in 2002. He previously served as president of OhioHealth's central Ohio hospitals.

John Bluford, CEO of Truman Medical Center (Kansas City, Mo.). Mr. Bluford has led Truman Medical Center for 13 years and has worked in hospital and health system administration for more than 30. Prior to his current role, he served as CEO of Hennepin County Medical Center in Minneapolis.

Jeffrey W. Bolton, CFO of Mayo Clinic (Rochester, Minn.). Mr. Bolton has been CFO at Mayo Clinic since 2003. He previously served as CFO at Carnegie Mellon University in Pittsburgh.

Marc Boom, MD, President and CEO of The Methodist Hospital System (Houston). Dr. Boom has served as president and CEO of The Methodist Hospital System since January 2012. He was previously executive vice president of Methodist Hospital in Houston for seven years.

Barry "Skipper" Bondurant, Administrator and CEO of Baptist Memorial Hospital-Union City (Tenn.). Mr. Bondurant joined Baptist Memorial Hospital-Union City as administrator and CEO in 2012. He previously served as administrator and CEO of Baptist Memorial Hospital-Tipton.

Marna P. Borgstrom, President and CEO of Yale-New Haven (Conn.) Hospital. Ms. Borgstrom joined Yale-New Haven Hospital in 1979 and became president and CEO in 2005.

Richard M. Bracken, Chairman and CEO of Hospital Corporation of America (Nashville, Tenn.). Mr. Bracken joined HCA in 1981. He was named president and COO in 2002 and became president and CEO in January 2009.

Tammie Brailsford, RN, Executive Vice President and COO of MemorialCare Health System (Fountain Valley, Calif.). Ms. Brailsford has held her current position since 2003, overseeing the system's electronic medical record adoption and implementing wellness initiatives and Lean management techniques.

Richard Breon, President and CEO of Spectrum Health System (Grand Rapids, Mich.). Mr. Breon has led Spectrum Health since 2000 with more than 35 years of healthcare administration experience, including time at the helm of St. Mary's Hospital and Medical Center in Evansville, Ind., and Mercy Hospital in Iowa City, Iowa.

Ruth W. Brinkley, CEO of KentuckyOne Health (Louisville, Ky.). Ms. Brinkley was named CEO of KentuckyOne in January 2012. The organization formed that same month from the merger of Jewish Hospital & St. Mary's HealthCare in Louisville and Saint Joseph Health System in Lexington.

Lynn Britton, President and CEO of Mercy (Chesterfield, Mo.). After joining Sisters of Mercy in 1992, Mr. Britton was named to the top post of the organization in January 2009. He held other leadership positions in the system throughout his career, including senior vice president.

Craig Broman, President of St. Cloud (Minn.) Hospital. In addition to his role as head of St. Cloud Hospital, Mr. Broman is ex-officio of the CentraCare Health Foundation, the philanthropic arm of St. Cloud Hospital's parent company, St. Cloud, Minn.-based CentraCare Health System.

David Bronson, MD, CEO of Cleveland Clinic Regional Hospitals (Cleveland). Dr. Bronson has been with Cleveland Clinic since 1992. He practices internal medicine on the main campus of the clinic and also serves as chairman of the board of governors of the American College of Physicians.

Dave Brooks, CEO of Providence Regional Medical Center Everett (Wash.). Prior to Mr. Brooks' current role, he was COO of Central DuPage Health in Winfield, Ill. He has also served executive leadership roles at CHRISTUS Health in Irving, Texas, Lovelace Health System in Albuquerque, N.M., and Henry Ford Health System in Detroit.

Michael Browder, President and CEO of Essent Healthcare (Nashville, Tenn.). Mr. Browder has worked with Essent Healthcare since 2001, shortly after Essent acquired its first hospital. Prior to becoming CEO, he served as executive vice president and CFO.

George J. Brown, MD, President and CEO of Legacy Health (Portland, Ore.). Dr. Brown, a gastroenterologist, became president and CEO of Legacy Health in August 2008. He previously served as COO of Tacoma, Wash.-based MultiCare Health System.

Warren S. Browner, MD, CEO of California Pacific Medical Center (San Francisco). In addition to leading CPMC, Dr. Browner is an adjunct professor of epidemiology and biostatistics at the University of California San Francisco School of Medicine.

W. Michael Bryant, President and CEO of Centra (Lynchburg, Va.). Mr. Bryant joined Centra in June 2011 from Peoria, Ill.-based Methodist Health Services Corp., which he led as president and CEO since 1999. He previously served as president and CEO of Robert Wood Johnson University Hospital Hamilton (N.J.) for 10 years.

Janice Burger, CEO of Providence St. Vincent Medical Center (Portland, Ore.). Ms. Burger has served as CEO since 2005. She has been working for Providence Health System, also based in Portland, Ore., since 1986.

Michael Burnett, President and Chief Administrative Officer of Piedmont Fayette Hospital (Fayetteville, Ga.). Mr. Burnett assumed his position as president of Piedmont Fayette in July 2012. He previously served as the hospital's COO since 2008.

Peter W. Butler, President and COO of Rush University Medical Center (Chicago). Mr. Butler served as executive vice president and COO of Rush University Medical Center for six years before being promoted to president and COO in 2010.

Gary S. Campbell, President and CEO of Centura Health (Englewood, Colo.). Mr. Campbell has served as president and CEO of Centura Health since July 2008.

Vincent C. Caponi, CEO of St. Vincent Health (Indianapolis). Mr. Caponi joined St. Vincent Health in September 1998, when the system was formed. He previously served as president and CEO of St. Vincent's Hospital in Birmingham, Ala.

William F. Carpenter III, Chairman and CEO of LifePoint Hospitals (Brentwood, Tenn.). Mr. Carpenter served as CEO of the company since 2006 and assumed his title as chairman of the board in 2010.

W. Larry Cash, CFO of Community Health Systems (Franklin, Tenn.). Mr. Cash joined CHS in 1997 with more than 35 years of prior healthcare experience. He formerly held senior-level financial positions with Columbia/HCA Healthcare, Humana and PricewaterhouseCoopers.

Alan H. Channing, President and CEO of Sinai Health System (Chicago). In addition to leading Sinai Health, Mr. Channing serves as the chair of the Illinois Hospital Association Board of Trustees for 2012.

Randal "Randy" Christophel, President and CEO of IU Health Goshen (Ind.). Mr. Christophel has led IU Health Goshen since February 2012. He previously served as CFO and COO of the hospital in his 17-year tenure.

Jack Cleary, CEO of Vanguard West Suburban Hospital (Oak Park, Ill.). Mr. Cleary became CEO of West Suburban Medical Center in 2010. He previously served as president of North Central Baptist Hospital in San Antonio.

Joan M. Coffman, President and CEO of St. Joseph's Hospital (Chippewa Falls, Wis.). Ms. Coffman was named to lead St. Joseph's in March 2010. She previously served as the hospital's COO for two years.

Michael D. Connelly, President and CEO of Catholic Health Partners (Cincinnati). Mr. Connelly has served as president and CEO since 1995. Prior to joining CHP, Mr. Connelly was regional executive and CEO of Daughters of Charity National Health System in Los Altos Hills, Calif.

100 Great Community Hospitals

By Kathleen Roney

100 Great Community Hospitals

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Community hospitals are a critical component to the American healthcare continuum. These hospitals are often the anchors of health and employment within their communities, providing patients with top-quality care close to home. The following hospitals have demonstrated commitments to the health of their local population through clinical excellence, community involvement and various other efforts.

To compile this list, the *Becker's Hospital Review* editorial team analyzed information, recognition and rankings from a variety of industry sources, including iVantage Health Analytics, Thomson Reuters, HealthGrades and the American Nurses Credentialing Center. Note: These hospitals include fewer than 550 patient beds and have minimal teaching programs.

AnMed Health Medical Center (Anderson, S.C.) AnMed Health Medical Center opened in 1908. The 461-bed facility has undergone many renovations and milestones over 104 years, including an affiliation agreement with Cannon Memorial Hospital in Pickens, S.C., and Carolinas HealthCare System in Charlotte, N.C., in 2009. AnMed Health was named to Thomson Reuters' 100 Top Hospitals in 2012. HealthGrades also awarded AnMed with its third consecutive Distinguished Hospital Award for Clinical Excellence in 2012, and it was named one of the 100 Best Hospitals in 2012.

Aspirus Wausau (Wis.) Hospital. Aspirus Wausau Hospital is a regional health resource for north central Wisconsin and the upper peninsula of Michigan. The Magnet facility has 321 beds and is staffed by 350 physicians in 35 specialties. The hospital is best known for its cardiovascular program, but it has also received recognition in many other specialties such as joint replacement, stroke care and women's health. HealthGrades awarded Aspirus Wausau with a 2011 and 2012 Distinguished Hospital Award for Clinical Excellence as well as a Patient Safety Excellence Award in 2011.

Augusta Health (Fisherville, Va.) Augusta Health is a 255-bed hospital located in the Shenandoah Valley. The hospital opened in 1994 and has grown to employ more than 2,300 staff members with 225 active full-time physicians. Augusta is a 2012 recipient of HealthGrades' Distinguished Hospital Award for Clinical Excellence. In 2012, the hospital was named to Thomson Reuters' 100 Top Hospitals for a second consecutive year.

Aurora BayCare Medical Center (Green Bay, Wis.) Aurora BayCare Medical Center is a joint venture

of Aurora Health Care in Milwaukee, Wis., and BayCare Clinic in Green Bay. The 167-bed, full service hospital serves communities throughout northeastern Wisconsin and Michigan's Upper Peninsula. Aurora BayCare has received Magnet accreditation for excellence in nursing, a HealthGrades' Distinguished Hospital Award for Clinical Excellence in 2012 and a HealthGrades' Patient Safety Excellence Award in 2010, 2011 and 2012. Additionally, the medical center was named a 2012 top regional hospital by *U.S. News & World Report*.

Bay Medical Center (Panama City, Fla.) Bay Medical Center was chartered in 1949. Today, the hospital has 323 beds, 2,000 employees and more than 250 physicians on staff. Bay Medical has received many accolades for clinical excellence, including a Distinguished Hospital Award for Clinical Excellence in 2010, 2011 and 2012 and recognition as one of the 50 Best Hospitals from HealthGrades in 2010, 2011 and 2012. In 2011, Bay Medical provided more than \$30 million in charity and uncompensated care to the community.

Beebe Medical Center (Lewes, Del.) Founded in 1916 by two physician brothers, Beebe Medical center is now a 210-bed, non-profit hospital offering inpatient, outpatient, emergency and diagnostic services. Beebe participates in many community events, including fundraisers for the American Cancer Society, American Heart Association and the American Diabetes Association. HealthGrades ranked the hospital in the top 5 percent in the nation for overall clinic excellence with a Distinguished Hospital Award for Clinical Excellence in 2012. In 2012, Beebe was also recognized by HealthGrades for excellence in coronary intervention, joint replacement, orthopedic surgery, pulmonary care and spine surgery.

Bon Secours St. Francis Health System (Greenville, S.C.) The Bon Secours St. Francis Health System was founded in 1932. The private, non-profit hospital has 3,482 employees and 338 beds. Bon Secours St. Francis offers many community resources including the Lifewise Senior Program, an outreach program for men and women age 55 and older that promotes physical, emotional, social and spiritual wellness through various activities, events and membership benefits. The hospital has received an Outstanding Patient Experience Award in 2010, 2011 and 2012 from HealthGrades and recognition for excellence in joint replacement and orthopedic surgery from HealthGrades in 2012.

Cape Cod Hospital (Hyannis, Mass.) The 259-bed Cape Cod Hospital has one of the busiest emergency departments in New England, providing emer-

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gency services to 84,000 patients annually. Cape Cod Hospital has more than 1,700 employees and more than 300 physicians on staff. The hospital brings approximately 1,000 babies into the world each year and performs more than 12,500 surgeries. HealthGrades has recognized Cape Cod with a Patient Safety Excellence Award in 2011 and 2012 as well as an Outstanding Patient Experience Award in 2011 and 2012.

Carolinas Medical Center – NorthEast (Concord, N.C.). Carolinas Medical Center-NorthEast provides healthcare services through an extensive inpatient and outpatient network including Jeff Gordon Children's Hospital, Hayes Family Center and Battle Cancer Center, all in Concord. The 457-bed, non-profit medical center has an arts and science council that supports cultural facilities by providing funds to the arts, sciences and historical partners in the Concord community. Additionally, Carolinas Medical Center-NorthEast has received numerous HealthGrades honors including a Patient Safety Excellence Award in 2012 and a Joint Replacement Excellence Award in 2011 and 2012.

Central DuPage Hospital (Winfield, Ill.). This nationally recognized 313-bed hospital is located in a western suburb of Chicago. Its patients benefit from its partnerships with local hospitals and a recent affiliation with Cleveland Clinic for adult oncology and cardiology services. For the last five years, Central DuPage Hospital has been named to Thomson Reuters' 100 Top Hospitals. In 2012, the hospital received recognition from HealthGrades for its excellence in neurosciences, neurosurgery and pulmonary and stroke care as well as a 2012 Patient Safety Excellence Award. Central DuPage is in the midst of a multi-year construction project to redefine its campus and streamline its services.

Chandler (Ariz.) Regional Medical Center. Chandler Regional Medical Center, a member of San Francisco-based Dignity Health, was built in 1965 to provide residents of the East Valley community with closer healthcare services. The hospital has received numerous accolades from HealthGrades, most notably a 2012 Distinguished Hospital Award for Clinical Excellence and a 2012 Patient Safety Excellence Award. Earlier this year, Chandler Regional collaborated with Mercy Gilbert (Ariz.) Medical Center to provide roughly \$250,000 in grants to 11 non-profits organizations in the community.

Chelsea (Mich.) Community Hospital. Chelsea Community Hospital was established in 1970. This non-profit hospital is part of Mich.-based Saint Joseph Mercy Health System, a member of Novi, Mich.-based Trinity Health. Press Ganey and HealthGrades have nationally recognized Chelsea Community for its quality of care and patient satisfaction. In 2010, 2011 and 2012, the hospital received an Outstanding Patient Experience Award from HealthGrades. In

March, the hospital broke ground on a two-story addition, which will add 54 new beds, a new emergency room, X-ray and imaging areas, outpatient rehab and therapy, a new front entrance and a new lobby.

Clermont Hospital (Batavia, Ohio). Clermont Hospital, a member of Mercy Health, was established in 1973. Since then, it has served as Clermont County's leading healthcare provider. The hospital features one of the region's newest and largest intensive care units and one of the region's first dedicated wound care centers. Clermont's pulmonary services earned it a 2012 Pulmonary Care Excellence Award from HealthGrades.

Columbus (Ind.) Regional Hospital. Columbus Regional Hospital is a 225-bed facility with 1,625 physicians, nurses and clinical staff members. In 2012, the hospital received recognition as one of the nation's 100 best hospitals for stroke care by HealthGrades. In 2010 and 2012, HealthGrades recognized the hospital for patient safety with a Patient Safety Excellence Award, indicating that its patient safety ratings are in the top 5 percent of U.S. hospitals. Columbus Regional is one of only 238 hospitals in the country and one of eleven hospitals in Indiana to receive this designation.

Danbury (Conn.) Hospital. Danbury Hospital is a 371-bed regional medical center and university teaching hospital associated with Yale University School of Medicine in New Haven, Conn., University of Connecticut School of Medicine in Farmington and University of Vermont College of Medicine in Burlington. The hospital has earned Magnet accreditation for nursing excellence and a Distinguished Hospital Award for Clinical Excellence in 2010 and 2012 as well as a Patient Safety Excellence Award in 2010 and 2011, both from HealthGrades. Danbury is the first hospital in Connecticut to become a member of the U.S. Green Building Council, a non-profit organization dedicated to sustainable building, design and construction.

Dixie Regional Medical Center (Saint George, Utah). Dixie Regional Medical Center is a 245-bed hospital and member of Salt Lake City-based Intermountain Healthcare. The medical center is the major referral center for northwestern Arizona, southeastern Nevada and southern Utah. Dixie Regional partners with the Huntsman Cancer Institute in Salt Lake City to provide cancer care to patients close to home. The medical center recently opened Gateway to Wellness, which is a collection of services including fitness classes, nutrition coaches and personalized medical fitness evaluations. In 2012, Dixie Regional received a Cardiac Surgery Excellence Award from HealthGrades.

Dupont Hospital (Fort Wayne, Ind.). Dupont Hospital is a joint venture between Lutheran Health Network in Fort Wayne and

more than 260 area physicians. HealthGrades has also recognized Dupont Hospital with an Outstanding Patient Experience Award in 2010, 2011 and 2012. In 2012, the hospital was also a 2012 Thomson Reuters Top 100 Hospital. In addition to its partnership with the local high school for CPR training, the 131-bed hospital is involved in a number of charitable events and community activities, including painting and landscaping projects.

Edward Hospital (Naperville, Ill.). Edward Hospital is located in the western suburbs of Chicago with campuses in Naperville and Plainfield, plus outpatient facilities and physician office locations throughout the region. The hospital has 309 patient rooms and 4,400 employees, including 1,350 nurses and a medical staff of 1,000 physicians, representing nearly 70 medical and surgical specialties and subspecialties. HealthGrades ranked Edward Hospital among the top 5 percent in the nation for cardiac services in 2010, 2011 and 2012; cardiac surgery in 2012; and coronary intervention in 2010, 2011 and 2012.

The Finley Hospital (Dubuque, Iowa). The Finley Hospital was established in 1890. Today, the hospital has 126 beds, 875 employees and provides more than \$5 million in annual community benefits. The hospital recently opened its Finley Heart Center, adding heart disease preventive services such as nuclear cardiologic imaging to the hospital. HealthGrades ranked The Finley Hospital in the top 5 percent of U.S. hospitals for general surgery in 2011 and 2012. The hospital also received an Outstanding Patient Experience Award in 2011 and 2012 and a Patient Safety Excellence Award in 2010, 2011 and 2012.

FirstHealth Moore Regional Hospital (Pinehurst, N.C.). FirstHealth Moore Regional Hospital is a 395-bed, acute-care, non-profit hospital serving a 15-county region in the Carolinas. It is the flagship hospital for N.C.-based FirstHealth of the Carolinas. Moore Regional opened in 1929 with 33 beds and a staff of 27. Now the hospital has an active medical staff of 249 physicians. Moore Regional has been recognized by HealthGrades as one of the nation's best hospitals in joint replacement and orthopedic surgery for three consecutive years. The hospital has also been recognized by HealthGrades with a Patient Safety Excellence Award in 2010 and 2012 and an Outstanding Patient Experience Award in 2010, 2011 and 2012.

Flagler Hospital (Saint Augustine, Fla.). Flagler Hospital has operated as a non-profit institution since its founding in 1889. This 335-bed, acute-care hospital ranked among the top 5 percent of U.S. hospitals for clinical excellence and patient safety for the past seven consecutive years. In 2011 and 2012, HealthGrades recognized Flagler as one of America's 50 Best Hospitals and awarded it the Distinguished Hospital Award for Clinical Excellence. In February, Fla-

ger expanded its no-smoking policy to prohibit smoking throughout the entire hospital campus to promote and improve the health of employees, patients and visitors.

Franciscan St. Francis Health – Indianapolis. Franciscan St. Francis Health's Indianapolis campus opened in 1995. The hospital is part of a network of 14 hospital campuses in Indiana and Illinois owned and operated by the Franciscan Alliance, a healthcare system in Mishawaka, Ind. The hospital was ranked in the top 5 percent nationally for clinical performance with the HealthGrades Distinguished Hospital Award for Clinical Excellence in 2012. The hospital also received recognition as one of the nation's best hospitals in cardiac care, coronary intervention and general surgery by HealthGrades in 2012. The hospital expanded its facility in March with a six-story inpatient tower.

Fremont (Neb.) Area Medical Center. Fremont Area Medical Center is a non-profit healthcare facility owned by Dodge County, chartered in 1940. The 202-bed facility has been recognized by HealthGrades with a Patient Safety Excellence Award in 2011 and an Outstanding Patient Experience Award in 2010, 2011 and 2012. FAMC has a variety of community benefit initiatives, many of which are spearheaded by the FAMC Foundation. The foundation has awarded \$150,000 through its scholarship fund to 182 students in health-related fields since 1989. Many of the scholarship recipients have gone on to serve the Fremont community as nurses, physicians, physician assistants and therapists.

Gaston Memorial Hospital (Gastonia, N.C.). Established in 1946, Gaston Memorial Hospital is the anchor of CaroMont Health. The 435-bed, non-profit hospital has received a variety of industry awards and recognition, including HealthGrades' Distinguished Hospital Award for Clinical Excellence in 2010, 2011 and 2012. In 2011, Gaston Memorial hosted the Gaston County Health Summit, an event that brought together leaders from community organizations and businesses to discuss ways to improve health and the relationship between providers and businesses.

Good Shepherd Medical Center (Longview, Texas). Good Shepherd Medical Center opened in 1935 as the 47-bed Gregg Memorial Hospital. After changing its name to Good Shepherd Medical Center in 1981 and undergoing multiple expansions, the hospital is now a 425-bed regional referral center. In May 2012, the hospital opened an emergency center in Kilgore, Texas. Good Shepherd Memorial has earned numerous awards for its clinical care and patient satisfaction, including a Patient Safety Excellence Award from HealthGrades in 2011.

Hamilton Medical Center (Dalton, Ga.). Hamilton Medical Center is a 282-bed, regional, acute-care hospital offering major medical, sur-

gical and diagnostic services. Included under Hamilton Medical Center are the Bradley Wellness Center, Hamilton Specialty Care, Hamilton Home Health and Hamilton Hospice. The hospital was named one of the nation's best regional hospitals according to *U.S. News & World Report*. HealthGrades has recognized Hamilton Medical with a 2012 Distinguished Hospital Award for Clinical Excellence and a 2011 Emergency Medicine Excellence Award.

Heartland Regional Medical Center (Saint Joseph, Mo.). Heartland Regional Medical Center is part of Heartland Health, an integrated healthcare delivery system. In 2012, HealthGrades recognized Heartland Regional as one of the nation's 100 best in general surgery, pulmonary care and gastrointestinal care. The hospital also received the Distinguished Hospital Award for Clinical Excellence from HealthGrades in 2012. The Heartland Foundation provides leadership and financial support for a range of programs and services including scholarships, community revitalization efforts and innovative approaches to health and quality of life improvements.

Holland (Mich.) Hospital. Holland Hospital is a leading hospital in the west Michigan lake-shore area, serving the greater Holland area and surrounding communities through Ottawa and Allegan counties. The non-profit, 189-bed hospital was founded more than 90 years ago. Holland Hospital has received national recognition as a top performing hospital including Magnet accreditation for nursing excellence and awards for excellence in critical care, patient experience, emergency medicine and patient safety from HealthGrades. HealthGrades also recognized Holland Hospital with a Distinguished Hospital Award for Clinical Excellence for the past three years. For seven years in a row, Holland Hospital has been named to Thomson Reuters' 100 Top Hospitals List.

Howard County General Hospital (Columbia, Md.). Howard County General Hospital has been serving the community for 40 years. In 1998, the hospital entered into a strategic partnership with Johns Hopkins Medicine. Last year, the 249-bed hospital had more than 19,000 admissions and upwards of 13,500 surgical procedures. More than 3,200 babies were delivered at the hospital last year, as well. The hospital received a Distinguished Hospital Award for Clinical Excellence in 2010 and 2011 and an Emergency Medicine Excellence Award for the past three years from HealthGrades.

Hunterdon Medical Center (Flemington, N.J.). Hunterdon Medical Center, part of Hunterdon Healthcare, opened its doors in 1953. The Magnet-accredited, 178-bed, non-profit community hospital treats more than 8,600 inpatients annually. Hunterdon Medical is a teaching hospital, and its family practice residency is one of the oldest in the nation. HealthGrades recognized the hospital for excellence in general surgery in 2010, gynecologic surgery in 2011 and 2011 and joint replacement in 2011.

Iredell Memorial Hospital (Statesville, N.C.). Iredell Memorial Hospital is a 247-bed, non-profit facility. The hospital employs approximately 1,600 people and has around 140 physicians on staff representing a variety of specialties. Iredell Memorial's community cancer program is certified by the American College of Surgeons' Commission on Cancer, and the hospital also offers the only diabetes program in the county to be recognized by the American Diabetes Association. The Magnet-accredited hospital has received HealthGrades' Patient Safety Excellence Award in 2011 and 2012 as well as an Outstanding Patient Experience Award in 2010, 2011 and 2012.

List Nominations Sought

Becker's Hospital Review is accepting nominations for the following upcoming lists:

- **100 CMOs to Know**
- **50 CEOs With the Longest Tenures**
- **100 Hospitals with Great Neurology Programs and more.**

To nominate an individual or organization, visit www.beckershospitalreview.com/lists/list-nominations.html

John Muir Medical Center (Walnut Creek, Calif.). John Muir Medical Center is the only trauma center for Contra Costa County and portions of Solano County. The 572-bed, Magnet-accredited hospital received a Distinguished Hospital Award for Clinical Excellence in 2012 for the third consecutive year and recognition as one of the nation's 100 best hospitals, both from HealthGrades. In April, the hospital announced plans to open John Muir Health Outpatient Center, which will house primary care physicians, some specialists, an urgent care center, patient education, laboratory and imaging services.

Kalispell (Mont.) Regional Medical Center. Kalispell Regional Medical Center is a regional referral center offering a full spectrum of healthcare services. The hospital has nearly 200 physicians on staff and 1,300 employees through 100 departments. In 2012, HealthGrades recognized Kalispell Regional Medical Center with a Distinguished Hospital Award for Clinical Excellence because KRMC's low complications and mortality rates are within the top 5 percent of hospitals in the country. KRMC was also recognized by HealthGrades with the Patient Safety Excellence Award and the Outstanding Patient Experience Award in 2012. Out of more than 5,000 hospitals in the United States, KRMC was one of only a few hospitals to earn all three designations.

Kent General Hospital (Dover, Del.). Kent General Hospital has served the Dover community since 1927. The hospital was one of the first in Delaware to offer intensity-modulated radiation therapy treatment for cancer, and its new Wound Care Center provides specialized treatment for chronic and nonhealing wounds. In 2012, Kent General received awards for excellence in gastrointestinal care, general surgery, pulmonary care and critical care as well as a Distinguished Hospital Award for Clinical Excellence in 2011 and 2012, a Patient Safety Excellence Award in 2011 and an Emergency Medicine Excellence Award in 2011 and 2012, all from HealthGrades.

King's Daughters Medical Center (Ashland, Ky.). King's Daughters Medical Center is a locally-controlled, non-profit, 465-bed regional referral center, covering a 150-mile radius that includes southern Ohio, eastern Kentucky and western West Virginia. Established in 1899, KDMC ranks fourth in the state of Kentucky in terms of overall admissions. In 2012, KDMC received an Emergency Medicine Excellence Award from HealthGrades for the third consecutive year. The hospital has also been awarded HealthGrades' Outstanding Patient Experience Award for the past three years.

Lancaster (Pa.) General Hospital. Lancaster General Hospital is a part of Lancaster General Health. The hospital has served the community's healthcare needs since 1893. Lancaster General has received many awards and recognitions; most notably it received HealthGrades' America's 50 Best Hospitals Award in 2010, 2011 and 2012, recognizing the hospital as among the top 5 percent in the nation for clinical and patient safety excellence. Additionally, HealthGrades awarded Lancaster General for its excellence in cardiac care, cardiac surgery and coronary interventions for three consecutive years.

Lynchburg (Va.) General Hospital. Lynchburg General Hospital is an emergency and critical care center that offers a range of specialty services, including cardiology, emergency medicine, orthopedics, oncology, neurology and neurosurgery. In 2011, Thomson Reuters named the 358-bed hospital as a Top 50 Cardiovascular Hospital. Lynchburg General received numerous recognitions from HealthGrades in 2012, including a Patient Safety Excellence Award and an Outstanding Patient Experience Award.

Major Hospital (Shelbyville, Ind.). Major Hospital has provided quality healthcare to individuals in Shelby County since it opened its doors in 1924. In 2012, HealthGrades recognized the hospital for its excellence in gastrointestinal care,

Becker's Hospital Review Annual Chief Executive Officer Strategy Roundtable

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| <p>1. Larry Anderson, CEO, Tri-City Medical Center</p> <p>2. Dave Brooks, CEO, Providence Regional Medical Center Everett</p> <p>3. Teri Fontenot, President and CEO, Women's Hospital</p> <p>4. Larry Goldberg, President and CEO, Loyola University Health System</p> | <p>5. Steve Goldstein, President and CEO, Strong Memorial Hospital</p> <p>6. Dean Harrison, President and CEO, Northwestern Memorial HealthCare</p> <p>7. Bill Leaver, President and CEO, Iowa Health System</p> <p>8. Barb Martin, President and CEO, Vista Health</p> | <p>9. Charles Martin, Chairman and CEO, Vanguard Health Systems</p> <p>10. Megan Perry, President, Sentara Potomac Hospital</p> <p>11. Jim Skogsbergh, President and CEO, Advocate Health Care</p> <p>12. Quint Studer, Consultant and Founder, Studer Group</p> |
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naming it among the nation's 100 best hospitals in that area. Major Hospital also received HealthGrades' Outstanding Patient Experience Award in 2012 for the third consecutive year.

Margaret Mary Community Hospital (Batesville, Ind.). Margaret Mary Community Hospital is a non-profit hospital providing inpatient and outpatient services to the Batesville community between Cincinnati and Indianapolis. The 25-bed hospital has served the community for more than 75 years, ever since a local family invited Sisters of the Poor of St. Francis to open a hospital in the area in 1930. Margaret Mary recently received its second consecutive Outstanding Achievement Award from the Commission on Cancer of the American College of Surgeons. This award was given to two cancer programs in the state of Indiana.

Martin Memorial Medical Center (Stuart, Fla.). Martin Memorial Medical Center is a part of Martin Health System, based in Stuart. The 244-bed medical center was named to Thomson Reuters' 2012 50 Top Cardiovascular Hospitals. Martin Health System was also named to Thomson Reuters' Top 100 Hospitals List in 2012. In addition, Martin Memorial has earned numerous HealthGrades awards, including recognition as one of America's 50 Best Hospitals for the past two years and the Distinguished Hospital Award for Clinical Excellence for the past three years.

Mary Greeley Medical Center (Ames, Iowa). Mary Greeley Medical Center is a regional referral center serving a 13-county region throughout central Iowa. The medical center opened in 1916, and since then it has grown into a 220-bed hospital with approximately 1,391 employees and a staff of 190 physicians. HealthGrades recognized the hospital with an Outstanding Patient Experience Award in 2012, and HealthGrades ranked Mary Greeley Medical among the nation's 100 best hospitals for gastrointestinal care.

McKay-Dee Hospital Center (Ogden, Utah). McKay-Dee Hospital Center is a member of Salt Lake City-based Intermountain Healthcare. The hospital offers nationally ranked programs including a heart and vascular institute and newborn intensive care unit. The hospital's cancer center was the only program in northern Utah to receive national breast cancer center accreditation. In 2012, McKay-Dee was a Thomson Reuter Top 100 Hospital. HealthGrades has also recognized the hospital with a Patient Safety Excellence Award in 2011 and 2011 and a Pediatric Patient Safety Excellence Award in 2010.

McKee Medical Center (Loveland, Colo.). McKee Medical Center began serving the Loveland, Colo., community in 1976. The 132-bed, acute-care hospital offers only private rooms to help individuals recover in a peaceful, healing environment. McKee's family birthing

suites offer moms a comfortable space for labor, delivery, recovery and postpartum care — without having to transfer rooms. Beyond distinguishing itself in obstetrics, the hospital received the Distinguished Hospital Award for Clinical Excellence as well as an Emergency Medicine Excellence Award from HealthGrades in 2012.

Meadows Regional Medical Center (Vidalia, Ga.). Meadows Regional Medical Center was established in 1963. Since then, it has seen major growth culminating in a state-of-the-art, 194,000-square-foot renovation in 2011. The medical center now has a technologically-advanced radiology department, six new surgical suites and a cardiovascular lab where physicians provide diagnostic and interventional cardiology services. HealthGrades has recognized Meadows Regional with an Outstanding Patient Experience Award for the past three years.

Memorial Hermann Katy (Texas) Hospital. Memorial Hermann Katy Hospital is a part of Memorial Hermann Healthcare System, the largest non-profit hospital system in Texas. Memorial Hermann Katy takes part in Memorial Hermann Healthcare System's Medical Mission, which was founded in 1999. The Medical Mission serves as a liaison between the resources of Memorial Hermann hospitals and underserved residents of global communities during natural disasters in the United States. Memorial Hermann Katy has received recognition from HealthGrades for excellence in pulmonary care, emergency medicine and stroke care. The hospital also received an Emergency Medicine Excellence Award from HealthGrades in 2012.

Memorial Hospital West (Pembroke Pines, Fla.). Memorial Hospital West opened in 1992 to help meet the diverse healthcare needs of the community. The hospital features advanced programs through its Cardiac and Vascular Institute, Memorial Cancer Institute and Neuroscience Center. Additionally, Memorial Hospital West has a separate children's emergency department affiliated with Joe DiMaggio Children's Hospital in Hollywood, Fla. Memorial Hospital has received numerous awards from HealthGrades. In 2012, the hospital received a Distinguished Hospital Award for Clinical Excellence, an Emergency Medicine Excellence Award and awards for its critical care, pulmonary care and stroke care.

Mercy Medical Center – North Iowa (Mason City). Mercy Medical Center-North Iowa is a non-profit, community healthcare system that offers comprehensive care for individuals throughout northern Iowa and southern Minnesota. The hospital was a 2012 Thomson Reuters Top 100 Hospital. Mercy Medical has also received a Patient Safety Excellence Award in 2010 and 2012, an Emergency Medicine Excellence Award in 2010 and 2011 as well as recognition for excellence in coronary intervention, general surgery and stroke care, all from HealthGrades.

Methodist Medical Center of Illinois (Peoria). Methodist Medical Center of Illinois is a 329-bed hospital in the heart of Peoria. Founded in 1900, Methodist provides a full range of services, with almost 600 board-certified physicians. In order to help patients become and stay healthy with a balanced and nutritional diet, Methodist Medical provides healthy recipes online. In 2012, HealthGrades ranked Methodist Medical within the top 5 percent of hospitals in the nation for stroke treatment and pulmonary care. The hospital has also received Patient Safety Excellence Award in 2010 and a Women's Health Excellence Award in 2012.

Middlesex Hospital (Middletown, Conn.). The 147-bed Middlesex Hospital has achieved Magnet accreditation for nursing excellence four times in a row. It has also been named to Thomson Reuters' Top 100 Hospitals four times — the only hospital in Connecticut to do so two years in a row. In 2012, Middlesex Hospital was the recipient of a Distinguished Hospital Award for Clinical Excellence for the third consecutive year, and it was named one of America's 100 Best Hospitals in 2012, both recognitions from HealthGrades.

Mills-Peninsula Medical Center (Burlingame, Calif.). Mills-Peninsula Medical Center, part of Sacramento-based Sutter Health, includes a 241-bed hospital and adjoining outpatient physician office. Mills-Peninsula Medical has received many quality awards from HealthGrades, including recognition on its list of America's 100 Best Hospitals in 2012, a 2012 Distinguished Hospital Award for Clinical Excellence and a 2012 Emergency Medicine Excellence Award.

Minden (La.) Medical Center. The 161-bed Minden Medical Center, a member of Brentwood, Tenn.-based LifePoint Hospitals, is a 161-bed hospital that dates back to 1926. In 2011, Minden Medical Center was also a 2012 Thomson Reuters' Top 100 Hospital. HealthGrades also recognized the hospital for its outstanding patient experience in 2011. In 2010, Minden Medical provided \$89.8 million in uncompensated care, which included more than \$8.8 million for charity care and bad debt. The hospital also recently finished a new medical pavilion — a \$1.7 million project consisting of three individual clinic spaces.

NCH North Naples (Fla.) Hospital. NCH's North Naples Hospital, part of Naples-based NCH Healthcare System, has 261 acute-care beds. The hospital caters to its patient population with the Brookdale Center for Healthy Aging, an acute-care unit for the elderly that incorporates care specialized for high-risk populations. The hospital has also recently added a patient tower offering patients a "spa-like" environment. In 2012, NCH North Naples was recognized for excellence in cardiac care and coronary intervention placing it among the nation's best hospitals in these areas, according to HealthGrades.

Neosho Memorial Regional Medical Center (Chanute, Kan.). Neosho Memorial Regional Medical Center is a 23-bed hospital that provides care to 45,000 residents in a 60-mile radius. Located in the southeast portion of the state, the hospital was established in 1930 as a private hospital by Dr. L.D. Johnson. Today, Neosho Memorial is a non-profit, county-owned critical access hospital. The hospital has received many awards for its quality service such as a 2011 Leadership in Quality Initiatives Award from Quorum Health Resources and a 2011 National Healthcare Organization of the Month Award from the Studer Group. The hospital also received a Governor's Award of Excellence in 2010 and 2011.

Newton-Wellesley Hospital (Newton, Mass.). Patients who visit Newton-Wellesley have access to more than 1,000 affiliated physicians. The hospital is a member of Boston-based Partners HealthCare, which includes Massachusetts General Hospital and Brigham and Women's Hospital, both in Boston. Newton-Wellesley started as a cottage hospital in 1880 and has grown into a 313-bed facility. The hospital received numerous accolades, including a Patient Safety Excellence Award in 2012 and an Outstanding Patient Experience Award in 2012, both from HealthGrades.

North Colorado Medical Center (Greeley). North Colorado Medical Center opened in 1904 as The Greeley Hospital. As the name changed over the years, the facility grew into a fully-accredited, 398-bed hospital with 250 staff physicians and 2,900 employees. NCMC professionals are nationally recognized for excellence in programs such as burn and trauma care. State-of-the-art technology such as iCare and telehealth programs offer extra monitoring for NCMC patients in intensive care units. In addition, the hospital has an intelligent obstetrics program, designed to reduce complications during labor and delivery. In 2012, NCMC received HealthGrades' Distinguished Hospital for Clinical Excellence Award for the third year in a row and recognition as one of America's 100 Best Hospitals.

Northeast Georgia Medical Center (Gainesville). Northeast Georgia Medical Center, which includes more than 500 physicians, was recognized by HealthGrades as one of the best in the state and among the top 5 percent in the nation for its cardiac care. It also received a Distinguished Hospital Award for Clinical Excellence — for the past three years — and was named within the top 5 percent in the nation for cardiac surgery, coronary intervention, critical care and general surgery. Northeast Georgia is currently building a new hospital about 18 miles outside of Gainesville. The hospital will house numerous physician specialties, an urgent care center and outpatient services including imaging, lab and physical and occupational therapy.

North Kansas City (Mo.) Hospital. Founded in 1958 as an 80-bed facility, North Kansas City Hospital continues to expand to

meet the needs of its growing community. Now the hospital has 451 beds, a medical staff of 600 physicians representing 49 medical specialties and 21,900 annual admissions. North Kansas City Hospital's spine surgical services are among the top 5 percent in the nation, according to HealthGrades. In 2012, the hospital has also received recognition for its patient safety, emergency medicine and pulmonary care excellence from HealthGrades.

Owensboro (Ky.) Medical Health System. Owensboro Medical Health System is a 477-bed hospital with 3,205 employees and 206 medical staff members. Owensboro admits more than 17,000 patients annually. In August 2010, Owensboro opened The Center for Integrative Medicine with affiliate Cooperative Health Services to blend primary care with complementary therapies. In 2012, Owensboro Medical was named to Thomson Reuters' 100 Top Hospitals and received a Distinguished Hospital Award for Clinical Excellence from HealthGrades.

Palmetto Health Baptist Easley (S.C.) Hospital. Baptist Easley Hospital has been part of the upstate South Carolina community since 1958. The 109-bed hospital is the result of a partnership between Palmetto Health in Columbia, S.C., and Greenville (S.C.) Hospital System University Medical Center. In 2012, Baptist Easley received an Outstanding Patient Experience Award from HealthGrades. In January, Baptist Easley began construction on a new medical complex to expand its orthopedic, physical therapy, X-ray and laboratory services.

Paoli (Pa.) Hospital. Paoli Hospital serves Philadelphia's Chester County with medical and surgical services that have been recognized on both regional and national levels. In 2012, Paoli was named to Thomson Reuters' 100 Top Hospitals List and *U.S. News & World Report's* Best Hospitals List. Paoli was also named a top performer in the CMS Premier healthcare alliance value-based purchasing Hospital Quality Incentive Demonstration, which rewarded hospitals for high quality care in six clinical areas. In 2011, the hospital received excellence awards for patient safety and patient experience from HealthGrades.

Parma (Ohio) Community General Hospital. Parma Community General Hospital is an independent, non-profit hospital in Cuyahoga County. Founded in 1961, Parma Hospital now has 348 beds with a medical staff of more than 500 physicians. The hospital has had computerized patient records since 1996 and electronic medication verification since 2006. In 2012, Parma Hospital received a Distinguished Hospital Award for Clinical Excellence, a Women's Health Excellence Award and a Patient Safety Excellence Award from HealthGrades. In May 2012, the hospital was one of the first hospitals in the greater Cleveland area to integrate a three-dimensional, high-definition surgical vision system into the operating room. This robotic system allows sur-

geons to view a patient's anatomy in three dimensions during minimally invasive laparoscopy.

Penrose-St. Francis Health Services (Colorado Springs, Colo.). Penrose-St. Francis Health Services is part of Englewood, Colo.-based Centura Health. In 2012, the 522-bed, acute-care facility expanded its emergency department. HealthGrades has named Penrose-St. Francis one of the 50 best hospitals for five consecutive years. It has also received HealthGrades' Distinguished Hospital Award for Clinical Excellence for three consecutive years.

Piedmont Fayette Hospital (Fayetteville, Ga.). Piedmont Fayette Hospital, part of Piedmont Healthcare, is a 157-bed, acute-care community hospital. Thomson Reuters named it one of the nation's 100 Top Hospitals for a fifth year in 2011. In 2012, the hospital received excellence awards in pulmonary care, joint replacement, critical care and orthopedic surgery as well as an Emergency Medicine Excellence Award and a Distinguished Hospital Award for Clinical Excellence from HealthGrades. The hospital became a tobacco-free campus beginning May 21, 2012.

Presbyterian Hospital (Charlotte, N.C.). Presbyterian Hospital is a private, non-profit regional medical center and one of the largest healthcare institutions in the Carolinas. It is the flagship hospital for Charlotte, N.C.-based Presbyterian Healthcare. Over the past two years, the Magnet-accredited hospital has been adding floors, hospital beds and expanding services. Last year, Presbyterian completed a four-story expansion, which houses state-of-the-art patient rooms and a 20-bed cardiac triage unit. The hospital also opened an outpatient surgery center in February. The 19,600-square-foot facility combines comprehensive surgical eye care, pediatric endoscopy and a diagnostic breast center. In each of the past three years, Presbyterian Hospital has received an Outstanding Patient Experience Award from HealthGrades.

Providence Holy Cross Medical Center (Mission Hills, Calif.). Providence Holy Cross Medical Center is a 377-bed, non-profit facility offering a full continuum of healthcare from inpatient and outpatient services to home healthcare, health education and community outreach programs. In 2012, HealthGrades awarded the hospital excellence awards in pulmonary care and stroke care. Providence Holy Cross has also earned Magnet accreditation for excellence in nursing services. This year the hospital is celebrating 25 years of trauma care as one of only two hospitals in the San Fernando Valley with a Level II trauma center designation.

Reid Hospital & Health Care Services (Richmond, Ind.). Reid Hospital & Health Care Services opened as Reid Memorial Hospital in 1905. Today, Reid Hospital boasts numerous national accreditations as a non-profit, 207-bed regional referral medical center serving east central Indiana and west central Ohio.

In 2012, Reid Hospital received a Patient Safety Excellence Award from HealthGrades. This year, the hospital is upgrading its vascular surgery suite with state-of-the-art software and monitoring systems.

Riverside Medical Center (Kankakee, Ill.). Established in 1964, Riverside Medical Center is a part of Riverside HealthCare, a fully integrated healthcare system serving the counties of Kankakee, Iroquois, Will, Grundy and beyond. The 325-bed hospital is nationally recognized and award winning. As the only hospital with Magnet designation in the area, it has been named a 100 Top Hospital by Thomson Reuters four times. In 2012, HealthGrades recognized Riverside with a Distinguished Hospital Award for Clinical Excellence and for excellence in joint replacement, orthopedic surgery, prostatectomy and stroke care. The hospital's orthopedic surgery places it among the top 5 percent in the nation, according to HealthGrades.

Riverwood Healthcare Center (Aitkin, Minn.). Located roughly 120 miles north of Minneapolis, the 24-bed Riverwood Healthcare Center has served Aitkin County and surrounding north central communities since 1955. In June, the hospital opened a new wing for support services to house 60 to 70 employees from multiple departments. In 2010 and 2011, Riverwood Healthcare received a Joint Replacement Excellence Award from HealthGrades. The hospital has also received an \$80,000 grant from the Minnesota affiliate of Susan G. Komen for the Cure to bring better breast health education and awareness to the Aitkin area.

Rogue Valley Medical Center (Medford, Ore.). In 2008, Rogue Valley Medical Center celebrated its 50th year serving the Oregon region. The 378-bed hospital recently collaborated with the Oregon Health & Science University Telemedicine Network to provide stroke patients with access to top stroke physicians at Oregon Health Sciences University in Portland through a robotic video-conferencing unit. In 2012, HealthGrades ranked Rogue Valley among the top 5 percent in the nation for its joint replacement, orthopedic surgery and prostatectomy. It also received recognition for excellence in stroke care, general surgery and critical care as well as a Distinguished Hospital Award for Clinical Excellence and an Emergency Medicine Excellence Award from HealthGrades.

Rockingham Memorial Hospital (Harrisonburg, Va.). Rockingham Memorial Hospital has provided healthcare services since 1912. The 238-bed hospital serves a seven-county area with a population close to 200,000, admitting more than 1,300 inpatients, nearly 192,000 outpatients and delivering close to 1,700 babies per year. The hospital provides its patients with an online health library, which offers healthy living tips, interactive tools and media as well as links to recent health news. In 2012, Rockingham received an Emergency Medi-

cine Excellence Award and a Coronary Intervention Excellence Award from HealthGrades.

Russell Medical Center (Alexander City, Ala.). Russell Medical Center is a non-profit, acute-care facility serving the healthcare needs of east central Alabama. The 55-bed hospital opened in 1923 and has collected many milestones over the years. In the beginning of this year, Russell Medical announced a joint venture with the University of Alabama Health Services Foundation in Birmingham to enhance oncology services for patients. The hospital also began construction on a new cardiac catheterization lab, scheduled to open this summer. Both initiatives aim to pursue high-quality care and improved patient outcomes. Fittingly, the hospital earned recognition for its outstanding patient experience from HealthGrades in 2011.

Rutherford Hospital (Rutherfordton, N.C.). Founded in 1906, Rutherford Hospital is a 143-bed acute-care hospital that provides inpatient, outpatient and emergency services to the residents of Rutherford County. The hospital is now part of a larger health system, Rutherford Regional Health System. In the past, Rutherford Hospital has been named to Thomson Reuters' 100 Top Hospitals four times. It also received recognition for excellence in general and gastrointestinal surgery from HealthGrades in 2011 and 2010. In 2012, the hospital opened Rutherford Wound Care and Hyperbarics and remodeled its ground floor.

Sacred Heart Hospital (Eau Claire, Wis.). Sacred Heart Hospital, an affiliate of Hospital Sisters Health System in Springfield, Ill., opened in 1889. Since then, it has grown into a 344-bed acute-care hospital that provides emergency department and regional cancer center services. In 2012, the hospital received an Emergency Medicine Excellence Award, a

Distinguished Hospital Award for Clinical Excellence and excellence awards in gynecological surgery and critical care from HealthGrades. In May, the hospital received the Environmental Leadership Circle Award for demonstrating the highest degree of commitment to environmental sustainability. Sacred Heart was also recently recertified as a Level III trauma center.

Sacred Heart Medical Center – Riverbend (Springfield, Ore.). Sacred Heart Medical Center – Riverbend, a member of Bellevue, Wash.-based PeaceHealth, is a 374-bed, acute-care hospital. In 2012, HealthGrades awarded the hospital for excellence in pulmonary care, general surgery and critical care. Sacred Heart also received a Distinguished Hospital Award for Clinical Excellence from HealthGrades in 2012. In February of this year, caregivers at Sacred Heart contributed a \$330,731 donation toward the Community Health Fund, a program that provides financial assistance to the under-and uninsured.

Saddleback Memorial Medical Center (Laguna Hills, Calif.). For more than 30 years, South Orange County residents have turned to Saddleback Memorial Medical Center for quality healthcare. The nationally-recognized hospital was named to Thomson Reuters' 100 Top Hospitals in 2012. For the past three consecutive years, HealthGrades awarded the hospital a Distinguished Hospital Award for Clinical Excellence and an Emergency Medicine Excellence Award.

St. Cloud (Minn.) Hospital. Since it was founded by the Sisters of the Order of St. Benedict in 1886, St. Cloud Hospital has grown from a small, community hospital to a comprehensive, high-quality regional medical center. Currently, the hospital has nearly 4,300 employees and a medical staff of 400 physicians. St. Cloud has

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been named a 100 Top Hospital by Thomson Reuters and one of America's Best Hospitals by *U.S. News & World Report* multiple times. HealthGrades named St. Cloud among the nation's top 5 percent for cardiac surgery, gastrointestinal care and general surgery in 2012.

Saint Elizabeth Boardman (Ohio) Health Center.

Located about 80 miles southeast of Cleveland, Saint Elizabeth Boardman Health Center features colors, nature, natural light, artwork, water features and classical music, which create a healing and calming environment. In 2012, St. Elizabeth Boardman was ranked among the top 5 percent in the nation for its pulmonary care and critical care by HealthGrades. The hospital also received recognition for its stroke care and an Emergency Medicine Excellence Award from HealthGrades.

St. Elizabeth Edgewood (Ky.)

Located approximately nine miles from Cincinnati, St. Elizabeth Edgewood is a member of St. Elizabeth Healthcare, one of the oldest, largest and most respected medical providers in the greater Cincinnati area. In 2012, the hospital was named one of America's 50 Best Hospitals by HealthGrades, and it received a Distinguished Hospital Award for Clinical Excellence, placing it among the nation's top 5 percent of hospitals.

Saint Luke's Hospital (Cedar Rapids, Iowa)

Saint Luke's Hospital has served the Cedar Rapids community since its founding more than 125 years ago. The 532-bed hospital is a member of Iowa Health System, which recently entered a collaboration with Wellmark Blue Cross and Blue Shield of Iowa for an accountable care organization. In 2012, Saint Luke's was a Thomson Reuters Top 100 Hospital for the fourth time. The hospital has also received numerous other awards: It was named one America's 50 Best Hospitals and received a Distinguished Hospital Award for Clinical Excellence for a third consecutive year, both distinctions from HealthGrades.

St. Mary's Hospital (Madison, Wis.)

St. Mary's Hospital opened its doors with 70 beds in September 1912. Since then, the hospital has

grown to include an outpatient surgery center, an off-site adult day health center, a home healthcare organization and three surgery centers. St. Mary's is a member of St. Louis-based SSM Healthcare, sponsored by the Franciscan Sisters of Mary, and has affiliations with St. Mary's Care Center, a skilled nursing center and the University of Wisconsin School of Medicine in Madison. In 2012, the hospital received a Patient Safety Excellence Award and an Outstanding Patient Experience Award from HealthGrades.

St. Patrick Hospital and Health Sciences Center (Missoula, Mont.)

St. Patrick Hospital opened in 1873 under the sponsorship of the Sisters of Providence. The hospital now has 253 licensed beds, and in 2011, it admitted more than 7,900 patients. In May, St. Patrick Hospital received the Healthy Hospital Award for saving \$352,293 by diverting 5,413 pounds of medical waste from landfills in 2010. In 2012, St. Patrick was ranked among the nation's top 5 percent for spine surgery excellence by HealthGrades.

Saint Thomas Hospital (Nashville, Tenn.)

Saint Thomas Hospital, a member of Nashville-based Saint Thomas Health, has been caring for patients for 113 years. Today, the non-profit hospital provides adult specialty care to more than 2 million residents of middle Tennessee, southwestern Kentucky and northern Alabama. Saint Thomas hosts 541 beds, including 40 critical care, 80 special care and 140 telemetry beds along with 750 affiliated physicians. In 2012, the hospital earned distinction as a Thomson Reuters Top 100 Hospital for the 11th time as well as a Distinguished Hospital Award for Clinical Excellence and a Patient Safety Excellence Award for the third consecutive year from HealthGrades.

St. Vincent Carmel (Ind.) Hospital

St. Vincent Carmel Hospital is a member of St. Vincent Health, a health system with locations across Indiana. The non-profit hospital recently expanded its emergency department and breast center and embarked on an expansion and renovation of its maternity unit. St. Vincent Carmel has received multiple quality and care excellence

awards. In 2012, it received an Outstanding Patient Experience Award for the third consecutive year from HealthGrades. Prior to that, the hospital was recognized for its excellence in stroke care and joint replacement in 2010.

San Jacinto Methodist Hospital (Baytown, Texas)

Located roughly 30 miles outside Houston, San Jacinto Methodist Hospital opened its doors in 1948 and continues to meet the needs of the community as the area's only non-profit, church-affiliated medical center. In 2012, the hospital received a Distinguished Hospital Award for Clinical Excellence from HealthGrades, placing it among the top 5 percent of the nation's hospitals for the fifth year. HealthGrades also ranked the hospital among the top 5 percent in the nation for critical care and the top 10 percent for stroke care. It was also named one of America's 100 Best Hospitals.

Santa Barbara (Calif.) Cottage Hospital

Founded in 1888, the 408-bed, acute-care teaching hospital is the largest of its kind between Los Angeles and the San Francisco Bay Area. Santa Barbara Cottage Hospital receives 18,000 annual patient admissions. The hospital received a Patient Safety Excellence Award from HealthGrades in 2012 as well as recognition for excellence in spine surgery, prostatectomy, gastrointestinal care and neurosurgery. Santa Barbara Cottage Hospital is currently replacing its inpatient care facilities at an estimated cost of more than \$700 million. The new hospital will feature 337 rooms, state-of-the-art operating suites, an emergency department expansion and sophisticated surgical and imaging technologies.

Scottsdale (Ariz.) Healthcare Shea Medical Center

Scottsdale Healthcare Shea Medical Center is a 433-bed, nationally recognized hospital. In 2012, HealthGrades ranked Scottsdale Healthcare Shea among the top 5 percent of hospitals in the nation for cardiac care, coronary intervention, gastrointestinal care and general surgery. In 2012, the hospital received a Distinguished Hospital Award for Clinical Excellence and a Patient Safety Excellence Award from HealthGrades. The hospital participates in Scottsdale Healthcare's Neighborhood Outreach Access to Health program, which provides medical and dental care to uninsured children in the Scottsdale area.

Scripps Green Hospital (La Jolla, Calif.)

Scripps Green Hospital has served the La Jolla and greater San Diego communities since 1977 and is home to a variety of medical "firsts." It offered one of San Diego's first liver transplant programs and was one of the nation's first hospitals to provide stem cell transplants. For the second year in a row, the hospital received a Distinguished Hospital Award for Clinical Excellence from HealthGrades as well as recognition for excellence in a variety of healthcare services. Scripps Green was also named a 2012 Best Hospital in Cardiology by *U.S. News & World Report*.

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Southeastern Regional Medical Center (Lumberton, N.C.). Southeastern Regional Medical Center, a non-profit organization, received an Outstanding Patient Experience Award in 2011 and a Distinguished Hospital Award for Clinical Excellence in 2012 from HealthGrades. Southeastern Regional also received excellence awards in cardiac care and pulmonary care from HealthGrades in 2012. The medical center has 452 beds and offers acute-care, intensive care and psychiatric care to more than 14,000 patients each year.

Spartanburg (S.C.) Regional Medical Center. Spartanburg Regional Medical Center has served its community for more than 90 years. The hospital is a part of Spartanburg Regional, an integrated healthcare delivery system that includes Spartanburg Regional Physician Group and other healthcare facilities. Spartanburg Regional will open its cancer center in 2013. The hospital has received numerous awards from HealthGrades including a Distinguished Hospital Award for Clinical Excellence in 2011 and an Outstanding Patient Experience Award in 2010. In 2012, Spartanburg Regional received a Women's Health Excellence Award and recognition for excellence in prostatectomy and pulmonary care from HealthGrades.

Thibodaux (La.) Regional Medical Center. Thibodaux Regional Medical Center is a federally-owned, 185-bed regional medical center, offering specialized services such as heart surgery, radiation oncology and neurology. The medical center has more than 900 employees and 111 active staff physicians along with 115 consulting and specialty physicians. In October 2008, Thibodaux Regional launched the third phase of a \$100 million facility renovation project to expand its state-of-the-art healing environment. In 2012, the hospital received its third consecutive Outstanding Patient Experience Award from HealthGrades.

Utah Valley Regional Medical Center (Provo). Utah Valley Regional Medical Center, a member of Salt Lake City-based Intermountain Healthcare, was founded in 1939 as Utah Valley Hospital with 55 beds and 38 physicians. Today, the hospital is a 221-bed Level II trauma center. Utah Valley recently received recognition from HealthGrades with a Patient Safety Excellence Award in 2012, an Outstanding Patient Experience Award in 2011 and a Maternity Care Excellence Award in 2011.

The Valley Hospital (Ridgewood, N.J.). Valley Hospital is a fully-accredited, acute-care, non-profit hospital serving more than 440,000

people in 32 towns in Bergen County and adjoining communities. The 451-bed hospital handles roughly 51,730 annual admissions, and most recent statistics name the hospital the second-busiest in the state of New Jersey. Valley Hospital has received many quality awards from HealthGrades, most notably an Outstanding Patient Experience Award in 2011 and a Women's Health Excellence Award in 2012 for the third consecutive year. In addition, in 2012, HealthGrades named the hospital among the top 5 percent of hospitals nationwide for cardiac care, cardiac surgery and coronary intervention.

Vassar Brothers Medical Center (Poughkeepsie, N.Y.). Vassar Brothers Medical Center is a 365-bed facility that has served New York's Mid-Hudson Valley since 1887. Located on the banks of the Hudson River, the hospital has established centers of excellence in cardiac services, cancer care and women and children's health services. In 2012, HealthGrades recognized Vassar Brothers with a Distinguished Hospital Award for Clinical Excellence and an Emergency Medicine Excellence Award.

Venice (Fla.) Regional Medical Center. Venice Regional Medical Center is a 312-bed regional healthcare system. The hospital's reputation of compassionate healthcare dates back to 1951, when four Venice physicians and a local businessman worked to open the hospital's doors. One of the first minimally invasive da Vinci Single-Site robotic surgeries was conducted at Venice Regional. In 2012, Venice Regional received recognition for its excellence in joint replacement, gynecologic surgery and orthopedic surgery by HealthGrades.

Verde Valley Medical Center (Cottonwood, Ariz.). Verde Valley Medical Center, a member of Flagstaff-based Northern Arizona Healthcare, has grown from a small outpatient clinic in 1939 to a full-service, 99-bed, non-profit hospital serving north central Arizona. The hospital has a medical staff of nearly 100 physicians representing 25 medical specialties. In 2012, Verde Valley was recognized by HealthGrades for patient safety excellence and for being among the top 5 percent of hospitals nationwide for gastrointestinal care and general surgery.

Waldo County General Hospital (Belfast, Maine). Waldo County Hospital has been serving the Belfast community for more than 110 years. The 25-bed hospital is a member of MaineHealth based in Portland, Maine. Earlier this year, the hospital received a \$50,000 grant

for a childhood obesity prevention program. Waldo County Hospital offers a variety of community benefit programs including MedAccess, a program that provides free medications to the uninsured and underinsured. According to the most recent data, the program provided approximately \$2.2 million in free medications in 2009. In 2011, the hospital received a Gynecologic Surgery Excellence Award from HealthGrades.

Waukesha (Wis.) Memorial Hospital. Waukesha Memorial Hospital was established in 1914 and has since grown into a 301-bed hospital with a medical staff of 668 physicians. A member of ProHealth Care system in Waukesha, the hospital recently received 39,321 emergency visits and performed 2,298 births and 405 open-heart surgeries in a year. In 2012, Waukesha received an Outstanding Patient Experience award from HealthGrades for the third consecutive year.

West Park Hospital (Cody, Wyo.). Located in northwest Wyoming, West Park Hospital is a 25-bed acute-care hospital that has adopted a Planetree philosophy as a model of healthcare. The Planetree model strives to enhance patient comfort by personalizing, humanizing and demystifying the healthcare experience. West Park Hospital received a Pulmonary Care Excellence Award in 2010 and 2011 and a Spine Surgery Excellence Award in 2011 and 2012 from HealthGrades.

Winchester (Va.) Medical Center. Winchester Medical Center is a 445-bed, non-profit, regional referral center offering a broad spectrum of services including diagnostic, medical, surgical and rehabilitative care. A Level II trauma center, Winchester Medical Center is a resource for 400,000 residents in a region known as the Top of Virginia, plus neighboring West Virginia and Maryland. The hospital employs more than 2,700 individuals and has a medical staff of more than 330 physicians, representing nearly every specialty. In 2012, Winchester Medical received a Patient Safety Excellence Award from HealthGrades.

Woodwinds Health (Woodbury, Minn.). Woodwinds Health, a collaboration between of HealthEast Care System in Saint Paul, Minn., and Children's Hospital and Clinics of Minnesota in Minneapolis, is an 86-bed hospital that opened in August 2000. Located on 30 acres of pristine wetlands, it is the only hospital in the southeast metro area. In 2012, Woodwinds was named one of the 100 Top Hospitals by Thomson Reuters. In 2012, the hospital also received an Outstanding Patient Experience Award from HealthGrades. ■

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Protecting and Preserving the Community Hospital — Immediate Actions for Future Success

By Sabrina Rodak

With the Supreme Court's recent decision to uphold the Patient Protection and Affordable Care Act, hospitals can now move into high gear preparing for new payment and delivery models. While many large systems and hospitals have already partnered with physicians and payors to create accountable care organizations and other relationships, smaller community hospitals may not have the resources to transform their organization as quickly.

David Pederson, chairman of the board of trustees at Great Plains Regional Medical Center in North Platte, Neb., and Mike Williams, president and CEO of Community Hospital Corp., share challenges community hospitals are facing and immediate actions they can take to survive in the current and future healthcare environment.

Challenges

Here are four of the top challenges facing community hospitals.

1. Revenue cycle. Medicare reimbursement levels are on the decline for hospitals. Community hospitals, many of which are safety-net hospitals, serve a disproportionate amount of Medicare and Medicaid patients and may thus suffer more from these cuts than larger hospitals that have a larger proportion of privately insured patients. In addition, many community hospitals do not have the clout to secure the best rates from managed care providers, whereas larger hospitals can often more easily negotiate with managed care providers to increase their revenue, according to Mr. Williams.

"Payors are expecting high quality and low cost," he says. "It's something community hospitals want to provide, but it's becoming more and more challenging as sources of reimbursement are diminished."

2. Access to capital. Community hospitals are also facing a lack of access to capital, in part due to reduced reimbursement, according to Mr. Williams. This lack of access prevents community hospitals from updating their facilities, which can affect patient volume and quality of care as buildings age.

3. Physician recruitment. A third challenge for community hospitals is recruitment of physicians and other healthcare personnel. The physician shortage is one reason for this difficulty. In addition, it is often difficult to attract the necessary mix of primary care physicians and specialists to remote or rural areas where many community hospitals are located, Mr. Williams says.

4. Hospital-physician alignment. Community hospitals, like all hospitals, also struggle to work cooperatively with their medical staff to improve quality and lower costs.

Immediate actions

Here are six actions community hospitals can take to ensure future success.

1. Optimize internal operations. Before looking externally for support, community hospitals should assess their internal operations and optimize efficiency, Mr. Williams says. "Are you providing care in the most cost-effective manner with the highest quality outcomes?" he asks.

2. Benchmark performance. Community hospitals can improve efficiency and increase savings by benchmarking performance against similar hospitals. Comparing clinical data can help hospitals identify opportunities for improvement and spur change. Improving performance can benefit the hospital not only directly by improving patient care and finances, but also indirectly by making it more attractive to potential partners, according to Mr. Williams.

3. Assess feasibility of independence. After a community hospital makes as many internal improvements as possible, it should assess the feasibility of remaining independent. The ability of a community hospital to remain independent depends on many factors, such as the size of the patient population and competition in the area, according to Mr. Williams. Community hospitals need to determine if they can sustain financial success not only in the current environment, but also in the future as the demand for integrated care grows.

4. Consider forming new relationships.

If internal improvements are not sufficient to compete in the marketplace, community hospitals should consider forming relationships with other organizations to help meet the demands of high quality and low cost.

When seeking a partner, community hospitals should evaluate the alignment of the hospital's culture and the culture of the potential partner, according to Mr. Williams. Having similar values will allow both organizations to work cooperatively toward their goals.

Define expectations

Community hospitals need to define their expectations upfront when discussing a potential partnership with another organization, such as a tertiary care hospital. Community hospitals may want to partner to address revenue cycle, access to capital, physician recruitment, physician alignment and health IT issues.

If a community hospital partners with a tertiary care hospital, it may expect to share the larger hospital's clout in negotiating contracts with managed care providers, which can improve reimbursement levels. The community hospital may also expect to gain the partner's revenue cycle expertise to maximize collections.

A community hospital may also want to partner with a tertiary care hospital to improve its ability to recruit and form collaborative relationships with physicians. Mr. Williams suggests there is a "halo effect" when a community hospital partners with a reputable institution, such that the community hospital becomes more attractive to physicians. Partnering with an academic medical center can be particularly helpful in recruitment efforts because it provides a pool of medical residents who are familiar with the community hospital through its affiliation with the academic medical center.

Understand responsibilities

Equally important as defining expectations is hospitals' understanding of what they must provide in return for the expected benefits of a partnership. For example, in exchange for



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access to capital, a tertiary care hospital will usually require a degree of authority in the community hospital's use of the capital, according to Mr. Williams. "To the extent [access to capital] is high on list of desirables, community hospitals have to understand they need to give up some level of control to achieve that," he says.

The level of control the community hospital will need to yield will depend in part on the amount of capital desired and the risk level of the investment. The tertiary care hospital may require representation on the community hospital's board, or the community hospital may need approval from the tertiary care partner before using the capital.

Authority in the partnership

The question of authority in a partnership is important, and community hospitals should weigh the benefit of increased capital to the cost of less control. "[Community hospitals] have to ask if they can achieve capital access by better operational performance," Mr. Williams says. "Are they looking for a quick infusion of capital or are they looking to improve processes? Improving processes they employ to provide care can make them more efficient, which leads to a better bottom line. With a better bottom line, they can [access] capital." By optimizing internal operations before seeking a partner, community hospitals may be able to improve their access to capital without sacrificing any authority.

Similarly, community hospitals can have different levels of authority depending on the type of organizations with which they form a relationship. For 22 years, North Platte Hospital Corp., which owns Great Plains Regional Medical Center, had a contract with a management company. Under this agreement, the management company employed the hospital CEO and CFO. Now, however, North Platte Hospital Corp. is in its third year of working with Community Hospital Corp. for consulting services. This arrangement enables North Platte Hospital Corp. to hire all employees, including the CEO, and take responsibility for all management, according to Mr. Pederson.

The consulting arrangement is less costly and allows the hospital to have more control, Mr. Pederson says. Specifically, the agreement enables the hospital board to fulfill its role in leading the hospital. "It's more cost effective but it also more clearly defines that [the board members] represent the owners of this hospital and we are the ones ultimately making the decisions. Obviously we have administration in place to handle the day-to-day operations, but we decide what programs we're going to have, what physicians and support staff we are going to need and things of that nature," he says.

5. Ensure board involvement. The future success of community hospitals also depends on the involvement of their board of directors and/or trustees. In fact, the board's engagement with the hospital administration and medical staff may be a determining factor in the hospital's ability to survive healthcare reform. "Whether a community hospital is able to stay independent depends on how hard the board is willing to work at keeping the hospital independent," Mr. Pederson says. "If board members are sitting in a ceremonial post and don't really get involved in the overall direction of the hospital, it's very possible that [the hospital] will end up needing to be purchased by some larger organization."

Educating the hospital board

To support a community hospital, the board needs to be educated on its responsibilities, including overseeing the hospital's finances, clinical quality and strategy. Hospital boards can become educated by meeting with the management team, studying publications on hospital boards and seeking other continuing education opportunities. "The board has to become educated and not delegate all the strategic direction [responsibilities] to the management team," Mr. Williams says.

Mr. Pederson says an important way the Great Plains Regional Medical Center board supports the hospital is by providing funding and other resources to create new services, such as interventional cardiology. When considering expanding service lines, the hospital board needs to first determine if there is a need for the service based on the patient population and competition in the marketplace. "It's going to take lot of extra work in terms of meetings and analysis to come to the conclusion that we do or do not have the capacity to add a program like interventional cardiology," Mr. Pederson says.

If the board decides there is a need for a new service, it should then help the management team bring together the physicians and equipment required to develop the service.

Providing accountability

One of the most important duties of a hospital board is holding hospital leaders accountable for the performance of the organization. To provide accountability, hospital boards need to analyze key metrics and ask questions. "With most boards there is a hesitancy to ask questions or to expect certain performance out of the people you hire to run the operation," Mr. Pederson says. "It is probably even more so [the case] in healthcare, where there are so many terms and laws that the lay person doesn't understand. [Board members] have to be willing to put forth some effort to ask questions about how things are working."

The board should look at finance and quality metrics, such as patient satisfaction scores, to monitor the hospital's performance and guide its strategic direction.

6. Collaborate with physicians. Community hospital leaders need to commit to a collaborative relationship with physicians to improve quality and cost efficiency. One way Great Plains Regional Medical Center builds a positive relationship between hospital executives and physicians is by including physicians in leadership positions. The hospital's bylaws require the board to include two physicians elected by the medical staff as well as the chief of staff and vice chief of staff, who are both physicians. Currently, physicians account for roughly one-third of the hospital's board. Involving physicians in the hospital's governance ensures they have a voice in the hospital's strategic decisions.

Hospital leaders can also develop a collaborative relationship with physicians by providing data to support their proposed changes. "Physicians are scientifically driven," Mr. Williams says. "A solid base of information technology that's not just hospital based, but that transcends the care delivery scheme into physicians' offices is mandatory for success in the future." ■

What the Health? How Hospital Leaders Can Prepare Their Systems for Reform

By Steve Whitehurst, Chief Customer and Strategy Officer, BerylHealth

Recently, the United States Supreme Court sent a monumental message to healthcare providers and patients across the country when it upheld the Patient Protection and Affordable Care Act, with the sole exception that Congress cannot penalize states that decline to expand Medicaid.

Implementation of the PPACA provisions provides great challenges for hospitals, which are also struggling with significant cost, operational and clinical hurdles as they attempt to implement the far-reaching reforms of PPACA and other mandates while maintaining financial viability in an era of evolving payment models with lower reimbursements.

In a time of reform, recession and reimbursement, rethinking how we deliver patient experiences has become one of the biggest priorities amongst hospital executives.

Patients vote on their experience every day in hospitals across America. They judge how well clinicians and physicians communicate with them, how often their needs were attended and how comfortable their care environment is. As if the quest to score in the top quartile of the Hospital Consumer Assessment of Healthcare Providers and Systems survey isn't important enough to maximize reimbursement, health systems are plagued by reimbursement for readmissions, yet struggle to keep the beds filled as a revenue stream. HCAHPS provides standardized survey metrics to gauge the patients' perceptions about their experience, but we all know just because a nurse answers the call light doesn't mean the patient is going to come back or become a promoter of the system.

So much evolution in the patient throughput and alignment with changing models leaves gaps in the patient experience that often go unnoticed until it shows up on a satisfaction survey or an error occurs. Align your hospital strategically to help manage the anticipated influx of patients who will now be eligible for insurance coverage and are likely to drive increased traffic to the emergency department.

1. Align your hospital and network physicians with patients' post-care delivery. Once discharged or released patients leave your hospital or network facility, ensure there is a comprehensive follow-up plan to question if patients are receiving the appropriate level of follow-up care. Return that revenue back into your system and network of providers through physician referrals, or the next visit will most likely be in the emergency department.

2. Always ask questions. Patients are more satisfied with their stay if they receive a phone call post-discharge. Beyond the stay in a hospital, a post-discharge call can extend the patient experience by providing a way for patients to ask questions, ensure medication compliance and identify adverse conditions, and ensure follow-up appointments are made. Healthcare is complex enough for the care providers who see patients all day long; it's harder for patients to find their way along a care path. As CMS continues to enforce higher patient satisfaction scores and lower readmissions, it is becoming more evident that improved satisfaction and readmission scores are not the only strategy to engaging patients and creating loyalty.

3. Higher level of care coordination keeps patients out of the hospital and emergency department. Fast forward to 2013 and beyond, the quest will continue to improve preventative health coverage, expand how health systems bundle care and improve cost and efficiency.

Data will be more important than ever in understanding patient demographics, patterns and medical history. Physicians can't be forgotten in this journey. With growing physician shortages, systems will be forced to employ more nurse practitioners and physician assistants. At the same time, the PPACA is slated to increase payments for primary care physicians in an attempt to protect access for newly insured Americans.

Healthcare delivery and management is complex; there are physician shortages, understaffed nurses and patients with steep expectations that are right in the midst of a political movement and monumental shift in delivery guidelines. The Supreme Court has spoken, but the clear winner has yet to be determined. ■

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

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How a Banker Turns Around a Struggling System: Q&A With Carlos Migoya, CEO of Jackson Health System

By Molly Gamble

When Carlos Migoya began his tenure as president and CEO of Miami's Jackson Health System in May 2011, he had no prior healthcare experience. Instead, the longtime Miami resident brought more than 35 years of banking expertise to the financially-troubled public health system, which was expected to lose \$400 million this fiscal year.

Mr. Migoya had faced dire financial situations before. He served as Miami's city manager in a time of crisis, resolving significant budget issues for the city pro bono. Time spent in multiple senior-level positions with Wachovia Bank left him with a firmer understanding of efficiency and appreciation for accessibility, two values he is trying to permanently instill at Jackson.

Driven by the goal to keep Jackson open, Mr. Migoya and his team announced a workforce reduction affecting 1,000 jobs in March. He also promised to donate his bonus to the Jackson Health Foundation if the layoffs saved the system money. So far, Jackson seems to be on the upswing. After months of consecutive profits — June was the third straight month the hospital was in the black — Mr. Migoya said the system's financial status was still serious, but no longer a crisis.

Here, Mr. Migoya discusses the transition from banking to healthcare, how he carried out the difficult decision to lay off employees and what he thinks the largest challenge for Jackson will be in years to come.

Question: Some industry experts have said healthcare has not been as innovative as other industries, such as banking, which has become more convenient and customer-focused in recent years. Coming from a banking background, what are your thoughts on this? What banking values could hospitals benefit from borrowing?

Carlos Migoya: I see a lot of similarities between the two industries. I think what the banking business has done, and what healthcare is doing more of, is making sure we're more accessible to our customers. I'm going to use the word "customer" instead of patient, because at the end of the day, they're the same thing.

About 40 years ago, the banking industry decided to go to a dramatic branching strategy. Probably 20 years ago, on a national level, you started seeing a lot of acquisitions. The [plan]

behind that was always to try and be more convenient. At Wachovia, we used to say, 'Bank the people where, how and when they want to be banked.' As banks were building more brick and mortar [through branches], it became evident that wasn't the only way to do it.

The other way was electronically, through the Internet or telephone. That dramatically improved the electronic side of the business to the point where a huge side of the business is done electronically compared to face-to-face. Individuals can make deposits through the Internet. Now, fast forward to healthcare. Hospitals focus on the inpatient side and look at ways to try and deal with the preventive side. Therefore, some of the financially stronger hospitals have started expanding tremendously into primary care, urgent care and emergency departments.

I think the healthcare business is starting to catch itself where banking was 20 years ago. Are we building too much brick and mortar? Do we need to focus on prevention, telemedicine and home healthcare? I think from that perspective, the healthcare industry is lagging behind the banking industry. Frankly, some of this preventive stuff has been mandated through regulations. It's not just healthcare driving more business. On the national level, as some of these big healthcare businesses come into play, there's more competition for the same patient. That means accessibility comes to play a much bigger role [in patient decisions].

Q: In March, you promised to donate your entire bonus to Jackson's foundation if the system saves money this year, post-workforce reduction. What propelled you to make that promise? Can you provide an update on Jackson's financial health?

CM: Here's the thing: When I came on board in May last year, Jackson's forecast was to lose \$400 million this fiscal year. So my focus was never on the bonus. Now we're on our fourth straight month of profitability — not that it's a big profit, but it's in the black, so we'll take it.

Unions have said the only reason I've tried to turn this [system] around is for my bonus, when really that was the last thing on my mind. So I said what I'd like to do is turn my bonus over to Jackson for something near and dear to me: the renovation of our labor and delivery rooms. Right now, it's going to be nip and tuck on whether we make profit, break even or lose a



slight amount of money. We have three months, but I hope we do make a profit and turn the bonus over to the foundation.

Q: As a lifelong Miami area resident, what does Jackson Health mean to the city? Do you feel a personal connection to this health system?

CM: I came from Cuba when I was 11 and moved to Miami. I grew up here. Miami is my home. When I retired from the bank, for one year I was doing the transformation of Miami finances as city manager. I saw all the issues going on with Jackson Health, and I said there is nothing bigger I can do for the community than leave the legacy of transforming and turning Jackson Health into a sustainable and profitable system for the future. It's a public hospital with several nationally and regionally ranked service lines. It's partnered with University of Miami and the great [physicians] we have here. To provide the care we do here at all levels, for those who can afford it and those who cannot, is very important to me.

My son was born here at 1.25 pounds in 1978, and the only reason he and his mother survived is because of Jackson Memorial. My mother was a living donor to my aunt in the 1980s. There are a lot of people in this community who can tell you great stories about their relatives and friends whose lives have been saved because of Jackson. I felt I had no choice but to step up and do my part in its transformation.

Q: I'm assuming the decision to implement a large layoff at Jackson didn't come easily. How did you confront that difficult decision?

CM: When I got here, I didn't have healthcare background. The management team we brought on board was very experienced, mostly in the private sector. It was very evident early on that we didn't have a system that appealed to the average HMO company. That was a combination of length of stay, as well as rightsizing inefficiency. If we're going to be appealing for HMO business, we needed to make sure we were as efficient as we could be.

It was evident that we needed to make a statement out there that we were an efficient organization with the right LOS averages for acute care with the right staffing. It wasn't like we came up with a number and said we must reduce [the workforce]. We had a management team and asked every director to figure out their necessary staffing level. It was a true right-sizing. A mass layoff is something that says we reduce 5, 10, 12 percent. Instead, we came about with a number we [agreed upon] with directors who need to implement it.

We are through our third month and we've proven the right-sizing came from the ground up. It was reviewed by all clinicians and health experts. I was the last signature. The bottom line is, 'Well, should you be letting people go to unemployment in times that are very difficult?' That is a very difficult decision, but our number one mission is to make sure we have our doors open.

The way I got comfortable with [the layoff], to some degree, is to think of it as making a reduction in force, making it grow right, and hopefully in the future we will be able to not only replace those who we had to reduce — but grow even further. It's like a tree. You have to prune it before it can grow again.

Q: As someone who was named health system CEO without previous healthcare experience, what skills, capabilities and attitudes do you find to be the most powerful — no matter what the industry?

CM: I think the number one most important skill set anyone can have is people skills — the ability to lead people, to present a situation and get a group of people to work toward a common goal. Even though I was in the banking industry for 40 years, the last 20 I was in a leadership role. People would say, 'Oh, you're in the banking business?' and I'd say I was in the *people* business. In any industry, what's most important is the ability to identify the main issues and drive a team toward that common vision.

Q: What issue has been the greatest source of frustration in the past year? What, if anything, has ruffled your feathers?

CM: There are so many things that have been challenging, but really, I haven't allowed anything to "ruffle our feathers," like you say. Our focus hasn't been on how these things happened, but how we turn them around. We've taken all the different sides of this, from management, regulatory and governance and asked, 'What are the opportunities?'

The biggest challenge ahead of us now is our physician strategy. This hospital has been predominantly [staffed by] academic physicians, who are great for research and critical services. But we need to make sure we also have community physicians in here to be attractive and provide the business necessary to offset some of the care for the uninsured. The biggest challenge ahead of us is making sure those physicians who have trained here come back and stay here.

Q: On the other hand, what is it about Jackson Health that makes you most proud?

CM: What makes me most proud is the amount of miracles that happen here. Thirty-three years ago, my 1.25-pound son survived. At any other hospital that's a miracle. Here, it's just another day. People come into a trauma center with maybe a 10-percent chance of surviving, and they do. That is probably the biggest point of pride. The business issues are only tools to make sure we can continue the type of miracle work we do here. ■

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25 Largest Non-Profit Hospitals in America

Here are the 25 largest non-profit hospitals in America, 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 parts of the following text.

1. New York Presbyterian Hospital/Weill Cornell Medical Center (New York City) — 2,286 beds
2. Florida Hospital Orlando — 2,067 beds
3. University of Pittsburgh Medical Center Presbyterian — 1,601 beds
4. Indiana University Health Methodist Hospital (Indianapolis) — 1,506 beds
5. Baptist Medical Center (San Antonio) — 1,443 beds
6. Montefiore Medical Center-Moses Division Hospital (Bronx, N.Y.) — 1,409 beds
7. Orlando (Fla.) Regional Medical Center — 1,401 beds
8. Methodist University Hospital (Memphis, Tenn.) — 1,296 beds
9. Barnes-Jewish Hospital (Saint Louis) — 1,284 beds
10. The Cleveland Clinic — 1,284 beds

11. Norton Hospital (Louisville, Ky.) — 1,263 beds
12. Buffalo (N.Y.) General Hospital — 1,241 beds
13. The Mount Sinai Medical Center (New York City) — 1,221 beds
14. North Shore University Hospital (Manhasset, N.Y.) — 1,080 beds
15. Christiana Hospital (Newark, Del.) — 1,075 beds
16. Beaumont Hospital-Royal Oak (Mich.) — 1,061 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) — 1,003 beds
20. Spectrum Health Butterworth Hospital (Grand Rapids, Mich.) — 978 beds
21. Aurora Saint Luke's Medical Center (Milwaukee) — 973 beds
22. Cedars-Sinai Medical Center (Los Angeles) — 955 beds
23. The Brookdale University Hospital and Medical Center (Brooklyn, N.Y.) — 955 beds
24. The Moses H. Cone Memorial Hospital (Greensboro, N.C.) — 930 beds
25. Mercy Hospital Saint 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. Edinburg (Texas) Regional Medical Center — 816 beds
2. Henrico Doctors' Hospital-Forest Campus (Richmond, Va.) — 809 beds
3. North Shore Medical Center (Miami) — 778 beds
4. Methodist Hospital (San Antonio) — 766 beds
5. CJW Medical Center-Chippenham Campus (Richmond, Va.) — 758 beds
6. Oklahoma University Medical Center (Oklahoma City) — 651 beds
7. Medical City Hospital (Dallas) — 645 beds
8. Brookwood Medical Center (Birmingham, Ala.) — 602 beds
9. Sunrise Hospital & Medical Center (Las Vegas) — 592 beds
10. Las Palmas Medical Center (El Paso, Texas) — 587 beds

11. McAllen (Texas) Medical Center — 572 beds
12. Centennial Medical Center (Nashville, Tenn.) — 570 beds
13. Hillcrest Medical Center (Tulsa, Okla.) — 535 beds
14. West Florida Hospital (Pensacola) — 531 beds
15. Doctors Hospital at Renaissance (Edinburg, Texas) — 530 beds
16. Saint Francis Hospital (Memphis, Tenn.) — 528 beds
17. Wesley Medical Center (Wichita, Kan.) — 525 beds
18. Providence Memorial Hospital (El Paso, Texas) — 508 beds
19. Hahnemann University Hospital (Philadelphia) — 496 beds
20. Saint David's Medical Center (Austin, Texas) — 475 beds
21. Delray Medical Center (Delray Beach, Fla.) — 465 beds
22. Saint Mary's Medical Center (West Palm Beach, Fla.) — 463 beds
23. Summerlin Hospital Medical Center (Las Vegas) — 454 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. Data are for short term acute-care hospitals, critical access hospitals and children's hospitals.

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 — \$9.86 billion
3. New York-Presbyterian Hospital/Weill Cornell Medical Center (New York City) — \$8.06 billion
4. Florida Hospital Orlando — \$8.01 billion
5. Cedars-Sinai Medical Center (Los Angeles) — \$7.99 billion
6. Stanford (Calif.) Hospital — \$6.71 billion
7. Montefiore Medical Center – Moses Division Hospital (Bronx, N.Y.) — \$6.49 billion
8. Hospital of the University of Pennsylvania (Philadelphia) — \$5.98 billion
9. Temple University Hospital (Philadelphia) — \$5.9 billion
10. Orlando Regional Medical Center — \$5.71 billion

11. Massachusetts General Hospital (Boston) — \$5.64 billion
12. Hackensack (N.J.) University Medical Center — \$4.83 billion
13. Crozer-Chester Medical Center (Upland, Pa.) — \$4.81 billion
14. Indiana University Health Methodist Hospital (Indianapolis) — \$4.75 billion
15. Brigham and Women's Hospital (Boston) — \$4.58 billion
16. Vanderbilt University Medical Center (Nashville, Tenn.) — \$4.52 billion
17. New York University Langone Medical Center (New York City) — \$4.21 billion
18. Tampa (Fla.) General Hospital — \$4.16 billion
19. Norton Hospital (Louisville, Ky.) — \$4.15 billion
20. Northwestern Memorial Hospital (Chicago) — \$4.15 billion
21. Thomas Jefferson University Hospital (Philadelphia) — \$4.12 billion
22. North Shore University Hospital (Manhasset, N.Y.) — \$4.09 billion
23. The Methodist Hospital (Houston) — \$4.04 billion
24. Loma Linda (Calif.) University Medical Center — \$3.95 billion
25. Duke University Hospital (Durham, N.C.) — \$3.92 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. Data are for short term acute-care hospitals, critical access hospitals and children's hospitals.

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) — \$3.03 billion
3. CJW Medical Center – Chippenham Campus (Richmond, Va.) — \$2.76 billion
4. Sunrise Hospital & Medical Center (Winchester, Nev.) — \$2.73 billion
5. Brookwood Medical Center (Birmingham, Ala.) — \$2.73 billion
6. Doctors Medical Center of Modesto (Calif.) — \$2.68 billion
7. Medical City Hospital (Dallas) — \$2.38 billion
8. Oklahoma University Medical Center (Oklahoma City) — \$2.30 billion
9. Las Palmas Medical Center (El Paso, Texas) — \$2.30 billion
10. JFK Medical Center (Edison, N.J.) — \$2.24 billion

11. Good Samaritan Hospital (San Jose, Calif.) — \$2.15 billion
12. North Florida Regional Medical Center (Gainesville, Fla.) — \$2.14 billion
13. Henrico Doctors' Hospital – Forest Campus (Richmond, Va.) — \$2.05 billion
14. Memorial Hospital (Jacksonville, Fla.) — \$2.02 billion
15. Centennial Medical Center (Frisco, Texas) — \$1.85 billion
16. Regional Medical Center of San Jose (Calif.) — \$1.79 billion
17. Riverside (Calif.) Community Hospital — \$1.77 billion
18. Brandon (Fla.) Regional Hospital — \$1.75 billion
19. Edinburg (Texas) Regional Medical Center — \$1.75 billion
20. Wesley Medical Center (Wichita, Kan.) — \$1.67 billion
21. Swedish Medical Center (Englewood, Colo.) — \$1.64 billion
22. Saint Christopher's Hospital for Children (Philadelphia) — \$1.64 billion
23. Clear Lake Regional Medical Center (Webster, Texas) — \$1.62 billion
24. Doctors Hospital at Renaissance (Edinburgh, Texas) — \$1.62 billion
25. Fountain Valley (Calif.) Regional Hospital and Medical Center — \$1.60 billion ■

15 Largest For-Profit Hospital Operators of 2012

Here are the 15 leading for-profit hospital operators in the country, as of May 2012, including specialty/surgical hospital operators.

Note: Companies are listed in order of the number of hospitals, based on the company's website.

Hospital Corporation of America (Nashville, Tenn.).

Number of hospitals: 164
CEO: Richard Bracken
2011 revenue: \$29.7 billion

Community Health Systems (Brentwood, Tenn.).

Number of hospitals: 134
CEO: Wayne Smith
2011 revenue: \$113.6 billion

Health Management Associates (Naples, Fla.).

Number of hospitals: 71
CEO: Gary D. Newsome
2011 revenue: \$5.8 billion

LifePoint Hospitals (Brentwood, Tenn.).

Number of hospitals: 53
CEO: William F. Carpenter III
2011 revenue: \$3.03 billion

Tenet Healthcare Corp. (Dallas).

Number of hospitals: 50
CEO: Trevor Fettor
2011 revenue: \$9.58 billion

Vanguard Health System (Nashville, Tenn.).

Number of hospitals: 28
CEO: Charles N. Martin, Jr.
2011 revenue: \$4.89 billion

Universal Health Services

(King of Prussia, Pa.).
Number of hospitals: 23 (acute care)
CEO: Alan B. Miller
2011 revenue: \$7.5 billion

IASIS Healthcare (Franklin, Tenn.).

Number of hospitals: 18 (acute care)
CEO: W. Carl Whitmer
2011 revenue: \$2.8 billion

Prime Healthcare Services (Ontario, Calif.).

Number of hospitals: 16
CEO: Prem Reddy, MD
2011 revenue: *Not available*

National Surgical Hospitals (Chicago).

Number of hospitals: 14 (Specialty/surgical)
CEO: John G. Rex-Waller
2011 revenue: *Not available*

Capella Healthcare (Brentwood, Tenn.).

Number of hospitals: 13
CEO: Daniel S. Slipkovich
2011 revenue: \$683.9 million

Ardent Health Services (Nashville, Tenn.).

Number of hospitals: 10
CEO: David T. Vandewater
2011 revenue: *Not available*

Steward Health Care System (Boston).

Number of hospitals: 10
CEO: Ralph de la Torre, MD
2011 revenue: *Not available*

SunLink Health Systems (Atlanta).

Number of hospitals: 7
CEO: Robert M. Thornton, Jr.
2011 revenue: \$181.2 million

Foundation Surgical Hospital Affiliates (Oklahoma City).

Number of hospitals: 4 (Specialty/surgical)
CEO: Thomas A. Michaud
2011 revenue: *Not available* ■

25 Largest Non-Profit Hospital Systems

Here are 25 of the largest non-profit health systems in the country, ranked in order by the number of hospitals in the system. The following list was devised with data from both the American Hospital Directory and each health system's respective website and/or public relations department.

Editors note: Figures represent the number of acute-care hospitals in the system, which may include specialty hospitals and children's hospitals. Outpatient care settings and clinics are not included. This list does not include public or government-owned hospital systems.

1. Ascension Health (St. Louis) — 81
2. Catholic Health Initiatives (Denver) — 76
3. Trinity Health (Novi, Mich.) — 49
4. Adventist Health System (Winter Park, Fla.) — 41
5. Dignity Health (San Francisco) — 40

6. Kaiser Foundation Hospitals (Oakland, Calif.) — 36
7. Catholic Health East (Newton Square, Pa.) — 35
8. Sanford Health (Sioux Falls, S.D. and Fargo, N.D.) — 34
9. Carolinas Healthcare System (Charlotte, N.C.) — 33
10. CHRISTUS Health (Irving, Texas) — 32
11. Providence Health System (Seattle) — 32
12. Mercy (Chesterfield, Mo.) — 31
13. Baylor Health Care System (Dallas, Texas) — 30
14. Avera Health (Sioux Falls, S.D.) — 29
15. Iowa Health System (Des Moines) — 26
16. Banner Health (Phoenix) — 25
17. Catholic Healthcare Partners (Cincinnati) — 24
18. Sutter Health (Sacramento, Calif.) — 24
19. Mayo Clinic (Rochester, Minn.) — 23
20. Intermountain Healthcare (Salt Lake City) — 22
21. NewYork-Presbyterian Healthcare System — 20
22. Adventist Health (Roseville, Calif.) — 19
23. Bon Secours Health System (Marriottsville, Md.) — 19
24. IU Health (Indianapolis) — 17
25. SSM Health Care (St. Louis) — 17 ■

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- **ASCs and the Next Four Years - Barry Tanner, President and CEO, Physicians Endoscopy, W. Michael Karnes, CFO and Co-Founder, Regent Surgical Health, Jim Stilley, MHA, FACHE, CEO, Northwest Michigan Surgery Center, Moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist**
- **Development and Business Model for Outpatient Spine and Sports Centers - Where the Future of Minimally Invasive Surgery will Lead - Robert S. Bray, Jr., M.D. and Karen Reiter, of D.I.S.C. Sports & Spine Center**
- **Debate on Healthcare Reform and More - Governor Howard Dean, Physician and former Six-term Governor of Vermont, former Chairman of the Democratic National Committee vs. Ari Fleischer, former White House Press Secretary and primary spokesperson for President Bush**
- **Joint Ventures - What Works and What Fails - Brent W. Lambert, MD, FACS, Principal & Founder, Nora Bass, VP of Surgery, Parkview Health, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP**
- **Chaos or Transformation? Healthcare Trends 2013 - David Jarrard, President & CEO, Jarrard Phillips Cate & Hancock, Inc., Michael E. Russell II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Robert Henry, Senior Vice President Development, Symbion, Inc., Steve Miller, Director of Government and Public Affairs, ASC Association, moderated by Stephanie A. Kennan, Senior Vice President Government Relations, McGuireWoods Consulting, LLC**
- **The Future of The ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates**



Howard Dean



Suzy Welch

- **The Best Ideas and Biggest Threats to ASCs - Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America, Robert Carrera, President, Pinnacle III, William M. Prentice, JD, Chief Executive Officer, Ambulatory Surgery Center Association, moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist**
- **A 75 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, SVP of Operations, Ambulatory Surgical Centers of America**
- **Shifting of Total Joint Surgery to an Outpatient Basis - Best Practices - John R. Moore, IV, MD, Orthopaedic & Joint Replacement Center, and, Tracey Harbour, RN, Administrator, Surgery Center of Pinehurst**
- **The Most Challenging Issues Facing ASC Administrators and How to Handle Them - Douglas G. Melton, CPA, Finance Director, Helena Surgicenter, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Melissa Szabad, Partner, McGuireWoods LLP**
- **Key Business and Clinical Issues for Endoscopy Centers - Larry Cohen, MD, and Jordan Fowler, CEO, Frontier Healthcare Management Services**
- **Orthopedics, Spine and Pain Management in ASCs - Michael R. Redler, MD, The OSM Center, Sev Hrywnak, DPM, MD, CEO, AASC, Inc, Yousuf Sayeed, MD, The Spine Center of DuPage Medical Group, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP**
- **How to Profit from Ophthalmology in ASCs - Danny Bundren, CPA, JD, Vice President Development/Operations, Symbion, Inc., Vickie Arjoyan, Administrator, Specialty Surgical of Beverly Hills**
- **160 speakers, 92 sessions**

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Improving the Profitability of Your ASC – Thrive Now and in the Future

This exclusive conference brings together surgeons, administrators and ASC business and clinical leaders to discuss how to improve your ASC and its bottom line in these challenging but opportunity-filled times.

The best minds in the ASC field will discuss opportunities for ASCs plus provide practical and immediately useful guidance on how to bring in more cases; improve reimbursement; manage, reduce and benchmark costs; introduce new specialties; engineer a turnaround; work on joint-ventures with hospitals and much, much more.

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- 2) Take discussion and thinking to the highest levels, focusing on the physician-owners, medical directors, ASC administrators and business minded directors of nursing.
- 3) Access expert views from all sides of the ASC world.

PROGRAM SCHEDULE

Pre Conference – Thursday October 25, 2012

11:30am – 1:00pm	Registration
1:00pm – 5:40pm	Pre-Conference
5:40pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 26, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 4:45pm	Main conference, Including Lunch and Exhibit Hall Breaks
4:45pm – 6:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 27, 2012

7:00am – 8:15am	Continental Breakfast
8:15am – 12:00pm	Conference

Thursday, October 25, 2012

11:30 – 4:30 PM

Registration and Exhibitor Set up

Concurrent Sessions

Track A - Improving Profits, Leadership and Transaction Issues

Track B - Costs, Benchmarking, Marketing, Social Media, and More

Track C - Key Specialties

Track D - Managed Care, Recruiting, Revenue Cycle

Track E - JVs, Physician Owned Hospitals, Selling Your ASCs

Track F - Quality, Infection Control, Accreditation, Management

1:00 – 1:40 PM

A. ASC Roundtable: Outlook for Investment and M&A Activity in the ASC Sector

Jason Cagle, SVP & General Counsel, United Surgical Partners International, Inc., Matt Searles, Managing Director, Merritt Healthcare, and Todd J. Mello, ASA, AVA, MBA, Partner, HealthCare Appraisers, Inc., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Out-Of-Network to Participating Provider

Bobby Sarnevesht, Managing Partner, Bay Area Surgical Management, Inc.

C. Moving Spine Procedures to ASCs – Key Business and Clinical Issues

D. Hospital Relationships - JVs, HOPDs and Co Management

Michael Weaver, VP Acquisitions Ambulatory Network, Vanguard Health, Donna Greene, Vice President Acquisitions & Development, Ambulatory Surgical Centers of America, and Robert Scheller, Jr., CPA, CASC, CEO, Lake Park Surgery Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

E. Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?

Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Robert C. Goettling, Principal, The Bloom Organization, Thomas J. Chirillo, Partner, Chirillo Consulting, Inc., and Patrick Simers, EVP, Principle Valuation, moderated by Scott Downing, Partner, McGuireWoods LLP

F. Creating a Culture of Clinical Accountability

Kelly Bemis, Group Director of Clinical Services, Surgical Care Affiliates

1:45 – 2:25 PM

A. What Can Football Teach Us About Surgery Center Management? Essentials for ASC Improvement

Joseph Zasa, JD, Partner, ASD Management

B. Perspectives from Great Administrators

Lori Martin, RN, BSN, R.T.(R), Administrator, Summit Surgery Center at Saint Mary's Galena, Karen Harris, Administrator, Clinical Manager, GNS - Surgery Center, Anne Roberts, RN, Administrator, Surgery Center of Reno, and Gary Richberg, Administrator, Pacific Rim Outpatient Surgery Center, moderated by Laura Miller, Editor-In-Chief, Becker's Spine Review, Managing Editor, Becker's ASC Review

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C. The Future of Pain Management - Bullish or Bearish?

Stephen Rosenbaum, CEO, and Robin Fowler, MD, Chairman, Medical Director, Interventional Management Services

D. Managed Care Contracting - 10 Key Steps

I. Naya Kehayes, MPH, Managing Principal and CEO, Eveia Health Consulting & Management

E. JVs - Can Your Center and An Aggressive Hospital Thrive Together?

Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, and Troy DeDecker, CEO, Health Management Associates, Inc.

F. How Do We Care For & Discharge Higher Acuity Patients in the Ambulatory Setting?

Gina Dolsen, RN, BSN, MA, Vice President of Operations, Blue Chip Surgical Center Partners

2:30 – 3:10 PM

A. Orthopedics and Spine- The Best Opportunities and Biggest Threats

Carl Balog, MD, and Stephen J. Dresnick, MD, President, Internal Fixation Systems, Robert S. Bray, Jr., MD, Neurological Spine Surgeon, D.I.S.C. Sports & Spine moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. What Makes a Great Physician Leader

Deedra Hartung, Senior VP, and Ben H. Brouhard, MD, Senior Vice President, Senior Search Consultant, Cejka Executive Search

C. Key Trends in Ambulatory Anesthesia

Rebecca S. Twersky, MD, MPH, Professor, Vice-Chair for Research, Dept. of Anesthesiology, Medical Director, Ambulatory Surgery Unit, SUNY Downstate Medical Center

D. Adding Cases and Recruiting Doctors

Brandon Frazier, Vice President of Development and Acquisitions, and Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America

E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements, Valuations and Other Issues

Jen Johnson, CFA, Managing Director, VMG Health

F. Key Issues in HFAP Accreditation

Beverly Robins, RN, BSN, MBA, Director of Accreditation, Healthcare Facilities Accreditation Program

3:15 – 3:55 PM

A. Investing in Healthcare - How PE Views ASCs and Different Sectors

Geoffrey C. Cockrell, Partner, McGuireWoods LLP, Joseph P. Nolan, Senior Advisor, GTGR,

David Pegg, Principal, Enhanced Equity Funds, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. ASC Direct Marketing Strategies

Ann Sells Miller, Partner, Advanced Healthcare Partners, and Peter S. Cunningham, President, CCO Healthcare Partners, LLC, Moderated by TBD

C. Great Specialties - How to Profit From ENT in ASCs?

Stephen Blake, CEO, Central Park ENT & Surgery Center

D. ICD-10

Kevin McDonald, SVP of Sales, Revenue Cycle Solutions Division, SourceMedical Solutions

E. Key Business Issues for Physician Owned Hospitals

R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

F. Making the Business Case for Infection Prevention to Key Stakeholders

Lorri A. Downs BSN, MS, RN, CIC Vice President of Clinical Services, Infection Prevention and Patient Safety, Board Certified, Medline Industries, Inc.

4:00 – 4:40 PM

A. Joint Ventures - What Works and What Fails

Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, Nora Bass, VP of Surgery, Parkview Health, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. The Use of Social Media by ASCs and Practices

Kim Woodruff, VP of Corporate Finance & Compliance, Pinnacle III

C. Development and Business Model for Out-patient Spine/Sports Centers - Where the Future of Minimally Invasive Surgery Will Lead?

Robert S. Bray, Jr., M.D. and Karen Reiter, of D.I.S.C. Sports & Spine Center

D. Healthcare Real Estate Roundtable: Opportunities in Healthcare Properties: The Role of Real Estate in Healthcare Deal Making

John T. Thomas, EVP Medical Facilities, Health Care REIT, Inc., Gordon A. Soderlund, SVP, Director - Business Development, Lend Lease Healthcare Development, Kenneth E. Seip, Vice President, Siemens Financial Services, Inc., Pedro J. Vergne, CEO and President, Physician's Capital Investments, moderated by Geoffrey C. Cockrell, Partner, McGuireWoods LLP

E. The Best Ideas Now; Key Ways to Improve Physician Owned Hospital Profits

Alex Rintoul, CEO, Medical Center at Elizabeth Place, Michael J. Lipomi, President & CEO, Surgical Management Professionals, moderated by Melissa Szabad, Partner McGuireWoods LLP

F. Evaluating Your Facility's IP Education Program

Janet Nau Franck, RN, MBA, CIC, APIC - Association for Professionals in Infection Control and Epidemiology

4:45 – 5:40 PM

KEYNOTE: Leadership and Management in 2012

Tony La Russa, former Major League Baseball Manager and infielder, 2011 World Series Manager, St. Louis Cardinals

5:40 – 7:15 PM

Networking Reception, Cash Raffles and Exhibits

Friday, October 26, 2012

7:00 – 8:00 AM – Registration and Continental Breakfast

8:00 – 8:10 AM – Introductions

8:10 – 8:50 AM

A. The Future of The ASC Industry

Andrew Hayek, President & CEO, Surgical Care Affiliates

B. Trends in the Employment of Key Specialties

LeeAnne Denney, Executive Vice President, iVantage Health Analytics

C. Adding Podiatry Residency Programs to ASCs

Robert Zasa, MSHHA, FACMPE, Founder, ASD Management

D. Key Business and Clinical Issues for Endoscopy Centers

Larry Cohen, MD, and Jordan Fowler, CEO, Frontier Healthcare Management Services

8:55 – 9:35 AM

A. ASCs and The Next Four Years

Susan Kizirian, Chief Operations Officer, Ambulatory Surgical Centers of America, Barry Tanner, President and CEO, Physicians Endoscopy, W. Michael Karnes, CFO and Co-Founder, Regent Surgical Health, Jim Stilley, MHA, FACHE, CEO, Northwest Michigan Surgery Center, Greg Koonsman, Senior Partner, VMG Health moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist

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B. Orthopedics, Spine and Pain Management in ASCs

Michael R. Redler, MD, The OSM Center, Sev Hrywnak, DPM, MD, CEO, AASC, Inc, Yousuf Sayeed, MD, The Spine Center of DuPage Medical Group, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them

Brian Brown, Regional Vice President Operations, Meridian Surgical Partners

D. Clinical Benchmarking in ASCs - How to Compare and Improve Quality

Carol Hiatt, RN, LHRM, CASC, Consultant and Accreditation Surveyor, Healthcare Consultants International

9:40 – 10:20 AM

A. The Best Ideas and Biggest Threats to ASCs

Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America, Robert Carrera, President, Pinnacle III, William M. Prentice, JD, Chief Executive Officer, ASCA, moderated by Suzy Welch, Author, Television Commentator, and Noted Business Journalist

B. How ASCs fit with ACOs

Jarod Moss, SVP Business Development, James Jackson, SVP Operations and Scott Nordlund, SVP of Strategic Growth, United Surgical Partners International

C. Maximizing ASC and Anesthesia Group Relationships

Charles Militana, MD, Director of Ambulatory Surgery Centers, North American Partners in Anesthesia, Director of Anesthesia, Dorothy & Alvin Schwartz Ambulatory Surgical Center, North Shore University Hospital North American Partners in Anesthesia

D. The 5 Measures of Success - Where Clinical, Financial and Operational Management Intersect

John Seitz, CEO MMX Holdings (ManageMy ASC), and Tamar Glaser, RN, CEO, Accreditation Services, Inc. and AccreditAbility, Inc.

E. The Myth of the Multiple

Jason L.Ruchaber, CFA, ASA, Partner, HealthCare Appraisers

F. Re-Evaluating Your Revenue Cycle

Sarah Martin, MBA, RN, CASC, Vice President of Operations, and April K. Sackos, CASC, Director of Business Operations, Meridian Surgical Partners

10:20 – 10:50 AM

Networking Break & Exhibits

10:50 – 11:30 AM

A. Double Digit Profit Growth in ASCs - How to Increase Profits in Challenging Times - Panel

Lisa Rock, President, National Medical Billing Services, Tom Mallon, CEO, Regent Surgical Health, Michael Doyle, CEO, Surgery Partners, Doug Golwas, SVP Ambulatory Surgery Center Sales, Medline Industries, Inc., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. The Most Challenging Issues Facing ASC Administrators and How to Handle Them

Douglas G. Melton, CPA, Finance Director, Helena Surgicenter, Marti Potter, Administrator, Jersey Shore Ambulatory Surgery Center, Melissa Szabad, Partner, McGuireWoods LLP

C. Orthopedic Implants and Technology Adoption for Physicians

John Cherf, MD, MPH, MBA, President, OrthoIndex

D. Key Issues in Managing the Supply Chain

Chris Klassen, VP Supply Chain, Surgical Care Affiliates

E. HR and Other Key Issues for ASCs

Thomas H. Jacobs, President, MedHQ

F. Clinical Quality in ASCs

Carla Shehata, RN, BSN, Director of Clinical Operations, Regent Surgical Health, Daren Smith, Director of Clinical Services, Surgical Management Professionals, Nicole Gritton, Vice President of Nursing and ASC Operations, Laser Spine Institute, moderated by Helen Suh, Associate, McGuireWoods LLP

11:35 – 12:30 PM – KEYNOTE

Healthcare Reform and More

Governor Howard Dean, Physician and Former Six-Term Governor of Vermont, Former Chairman of the Democratic National Committee vs Ari Fleischer, former White House Press Secretary and Primary Spokesperson for President Bush

12:30 – 1:30 PM

Networking Lunch & Exhibits

Concurrent Sessions

Track A - Improving Profits, General Sessions

Track B - Co-Management, Supply Costs, Management

Track C - Key Specialties

Track D - Benchmarking, Out-of-Network

Track E - Joint Ventures, Managed Care and Contracting for ASCs

Track F - Quality, Infection Control, Accreditation, Management

1:30 – 2:10 PM

A. Chaos or Transformation? Healthcare Trends 2013

David Jarrard, President & CEO, Jarrard Phillips Cate & Hancock, Inc., Robert Henry, Senior Vice President Development, Symbion, Inc., Steve Miller, Director of Government and Public Affairs, ASCA, moderated by Stephanie A. Kennan, Senior Vice President Government Relations, McGuireWoods Consulting, LLC

B. Improve Physician Alignment through "Nontraditional" Hospital Joint Venture Surgery Centers

Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners, and Nathan VanGenderen, CFO, Sentara Northern Virginia Medical Center

C. Endoscopy - The Keys to a Highly Successful Endoscopy Center

Barry Tanner, President & CEO, Physicians Endoscopy, John Poisson, EVP New Business Development, Physicians Endoscopy

1:30 – 2:50 PM

D. A 75 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits

Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, SVP of Operations, Ambulatory Surgical Centers of America

1:30 – 2:10 PM

E. Key Aspects to Relationships Between ASCs and Hospitals

Larry D. Taylor, President & CEO, Practice Partners in Healthcare, and Sean McNally, CEO, Moore Clinic

F. 10 Key Legal Trends in Infection Control

Dotty Bollinger, RN, JD, CASC, LHRM, Chief Operating Officer, Laser Spine Institute

2:15 – 2:50 PM

A. How to Recruit Orthopedics - Key Steps and Timelines

Jimbo Cross, Vice President Acquisitions & Development, Jeff Peo, Vice President Acquisitions and Development, and Brandon Frazier, Vice President of Acquisitions and Development, Ambulatory Surgical Centers of America

B. Implement Spine to Drive Higher Performance of your Surgery Center

Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners, and John Caruso, MD, FACS, Neurosurgeon, Parkway Surgery Center

C. How to Profit from Ophthalmology in ASCs

Danny Bundren, CPA, JD, Vice President, Development /Operations, Symbion, Inc., Vickie Arjyan, Administrator, Specialty Surgical of Beverly Hills

E. How to Structure a Great Joint Venture

Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

F. The Challenges Facing ASCs to Capture, Track and Report on Key Quality Indicators and Outcomes Data

Jennifer Brown, RN, Endoscopy Nurse Manager, Gastroenterology Associates of Central Virginia, and Tim Meakem, MD, Medical Director, ProVation Medical

2:50 – 3:20 PM
Networking Break & Exhibits

3:20 – 4:00 PM

A. How to Maintain Practice Independence While Effectively Partnering with Hospitals

Charles "Chuck" Peck, MD, FACP, President & CEO, and Christian Ellison, Vice President, Health Inventures, LLC

B. Co Management and Converting to an HOPD Model - How Does it Work - A Case Study

Tom Yerden, CEO, TRY Healthcare Solutions

C. Value Priced Implants for Spine and Orthopedic Surgery

Blair Rhode, MD, ROG, Sports Medicine, Orland Park Orthopedics

D. Handling Out of Network Successfully From a Billing and Coding Perspective

Lisa Rock, President, National Medical Billing Services

E. ASCs - How to Negotiate with Payors

I. Naya Kehayes, MPH, Managing Principal and CEO, Eveia Health Consulting & Management

F. Health Insurance Plans Are Taking Notice in Fraud and Abuse of Surgical Implants - What Are They Figuring Out and How to Prevent It

Steven Arnold, MD, Chief Medical Officer, Access MediQuip

4:05 – 4:45 PM

A. The EMR Challenge...

- The right Surgery Center Strategy

Chris Revell, PMP, Project Manager, Surgical Notes, Wendy Kelly, Administrator, Cool Springs Surgery Center, moderated by Robert Brownd, Director of Business Development, Surgical Notes

B. Small Scale Materials Management Success

Daren Smith, Director of Clinical Services, Surgical Management Professionals

C. Emerging Issues in ASC and Healthcare Litigation

Jeffrey Clark, Partner, Angelo Russo, Partner, Christina Egan, Partner, McGuireWoods LLP
Moderated by David Pivnick, Associate, McGuireWoods LLP

D. Key Strategies for Out of Network

Suzanne Webb, Owner, ASC Billing Specialists, LLC

E. ASC Transaction Valuation Issues

Kevin McDonough, Senior Manager, and Colin Park, Manager, VMG Health

F. 8 Keys to a Successful AAAHC Survey

Gina Dolsen, RN, BSN, MA, Vice President of Operations, Blue Chip Surgical Center Partners

Roundtable Discussions

Investment Trends in Healthcare

Joseph M. Scandariato Jr., CIMA, Managing Director - Wealth Management, Wealth Management Advisor, The Scandariato Group, Merrill Lynch

4:45 – 6:00 PM

Networking Reception, Cash Raffles & Exhibits

Saturday, October 27, 2012

7:15 – 8:15 am – Continental Breakfast

8:15 – 8:55 AM

A. ASC 2012 - Perspectives from Physicians Leaders

David Shapiro, MD CHC CHCQM CHPRM LHRM, Red Hills Surgical Center, Adam J. Locketz, MD, Health East Media Director of Spine Care, HealthEast Spine Center, Lawrence R. Kosinski, MD, MBA, AGAF, FACG, Elgin Gastroenterology, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Shifting of Total Joint Surgery to an Outpatient Basis - Best Practices

John R. Moore, IV, MD, Orthopaedic & Joint Replacement Center, and, Tracey Harbour, RN, Administrator, Surgery Center of Pinehurst, Nueterra Healthcare

C. Co-Management Arrangements

Brendan Snyder, President, Healthcare Strategy & Research Consultants, Nicholas Colyvas, MD, Chief Medical Officer, Healthcare Strategy & Research Consultants

D. Essentials of the Life Safety Code - How To Assure Compliance

Alice Epstein, Director, Risk Control, CNA HealthPro

8:55 – 9:35 AM

A. Develop a Great Same Story Growth Strategy

Chris Bishop, SVP Acquisitions & Business Development, and Amanda Kane, Business Development Manager, Blue Chip Surgical Center Partners

B. The Best Practices for Business Office Operations

Carolyn Whitsel, Senior Director Business Office Operations, United Surgical Partners International, Sharon Benson, MBA, MSN, RN, CASC, Vice President of Operations, Ambulatory Surgical Centers of America, moderated by Holly Carnell, Associate, McGuireWoods LLP

C. JVs with Academic Medical Centers

Bo Hjorth, Vice President Business Development, and Mike McKevitt, Senior Vice President, Regent Surgical Health

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

Ann Geier, RN, MS, CNOR, CASC, Vice President, Ambulatory Surgical Centers of America, Thomas H. Jacobs, President, John Merski, Partner, EVP of Human Resources, MedHQ, Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center

9:40 – 10:20 AM

A. Benchmarking the Financial Solvency of an ASC

Raj Chopra, CFO, The C/N Group, Inc.

B. Sell Your ASC or Stay the Course - Key Considerations

Scott Downing, Partner, Helen Suh, Associate, McGuireWoods LLP

C. Key Practices to Improve Infection Rates and Clinical Quality

Sandra Jones, MBA, MS, CASC, FHFMA, Executive Vice President, ASD Management

D. \$3MM Verdict in Chatham Surgicore v. HCSC, Insight from an Out of Network, Unlicensed Facility Case

Doug Prochnow, Partner, Edwards Wildman Palmer, LLP

10:25 – 11:05 AM

A. Critical Benchmarking Steps for ASCs

Lesley Raskin, Director of Surgery, Surgical Care Affiliates

B. Analytics Behind Physician Integration

Jeffrey Mason, CEO, BayCare Health System

C. Converting an ASC to an HOPB

Robert W. Scheller, Jr., CPA, CASC, CEO, Lake Park Surgery Center

D. Critical Communication Skills for ASC Administrators and Physician Leaders

Keri Talcott Director of Corporate Communications, and Traci Albers, Executive Director, High Pointe Surgery Center & North Memorial Ambulatory Surgery Center

11:10 – 12:00 PM

A. Conducting a Compliance Review of Your ASC or Physician Owned Hospital - Key Legal Issues for 2012 - 2013

Holly Carnell, Associate, Katherine Lin, Associate, Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:00 PM – Meeting Adjourns

CONFERENCE SPEAKERS

Great topics and speakers focused on key business, financial, clinical and legal issues facing ambulatory surgery centers • 92 Sessions, 160 Speakers

Traci Albers, Executive Director, High Pointe Surgery Center & North Memorial Ambulatory Surgery Center
Vickie Arjyan, Administrator, Specialty Surgical of Beverly Hills
Steven Arnold, MD, Chief Medical Officer, Access MediQuip
Carl Balog, MD
Nora Bass, VP of Surgery, Parkview Health
Scott Becker, JD, CPA, Partner, McGuireWoods LLP
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Thomas J. Chirillo, Partner, Chirillo Consulting, LLC
Raj Chopra, CFO, The C/N Group, Inc.
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Lorri A. Downs, BSN, MS, RN, CIC, VP of Clinical Services, Infection Prevention and Patient Safety, Board Certified, Medline Industries, Inc.
Mike Doyle, CEO, Surgery Partners
Stephen Dresnick, MD, President, Internal Fixation Systems

Christina Egan, Partner, McGuireWoods LLP
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Alice Epstein, Director, Risk Control, CNA HealthPro
Janet Nau Franck, RN, MBA, CIC, APIC - Association for Professionals in Infection Control and Epidemiology
Ari Fleischer, former White House Press Secretary and Primary Spokesperson for President Bush
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Advancing Accountable Care: 5 Hospital ACO Leaders Share Insight

By Bob Spoerl

CMS' July announcement of 89 new accountable care organizations participating in the Medicare Shared Savings Program emphasizes a trend happening on the commercial side of things, too: ACOs or similar models are sprouting up across the nation, with many health systems and hospitals considering ways to get in the ACO game.

But ACOs don't appear overnight. They demand months, sometimes even years, of strategic planning and cooperation between providers and payors.

Here, a panel of five health system leaders from ACOs across the nation reflects on some of the breakthroughs and challenges involved in establishing their organization. The leaders represent Phoenix-based Banner Health Network, which is in a commercial ACO relationship with Aetna and was the first ACO accepted into CMS' Pioneer ACO program in late 2011; Walnut Creek, Calif.-based John Muir Health, part of a commercial ACO with Blue Shield of California, as well as a participant in the Medicare Shared Savings Program; Appleton, Wis.-based ThedaCare, a CMS Pioneer ACO in a partnership with Bellin Health Care; and Marietta, Ga.-based WellStar Health System, recently accepted into the MSSP.

Question: Five years ago, would you have ever imagined leading something akin to an ACO?

Dean Gruner, MD, President and CEO, ThedaCare: Actually, yes. The reason I say that is I think many of us believe that one of the root causes of the cost crisis in healthcare in this country is the fee-for-service payment methodology.

When I was in Washington a few years ago, I talked to members of both political parties. Both seemed to agree that there needed to be something other than fee-for-service payments as well as a way to better support primary care in this country.

I think it's been very slow for payment reform; in fact, you don't hear either political party talk much about payment reform. People tend to broad brush things and say you are either for or against the Affordable Care Act. But I believe most politicians believe that 80 percent or more of that legislation was good.

Chuck Lehn, CEO, Banner Health Network: Yes. I think most in the industry have understood for a while that some level of realignment between purchasers, providers and consumers would occur mostly due to rising costs.

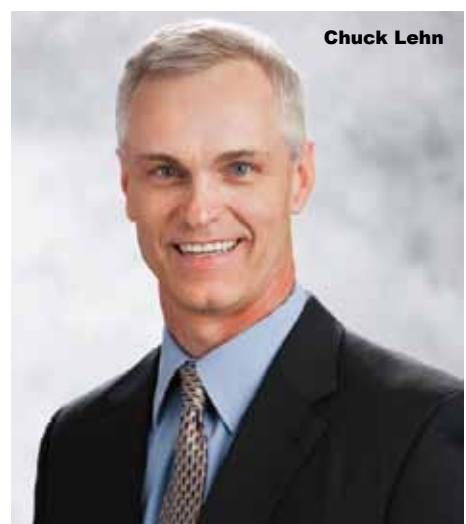
Mitchell Zack, Vice President of Employer and Payor Relations, John Muir Health: We started years before the ACO concept was founded — our history as an integrated system turned out to be integral to our success. We already had key components of an integrated care foundation built, and the ACO fit into that foundation.

Q: What was the most important thing you did as an executive building your ACO's foundation?

Marcia Delk, MD, Senior Vice President and Chief Quality and Safety Officer, WellStar Health System: Persevering. Part of this is about understanding where the journey is heading so you know what you need to do to assist your organization in adjusting to change. Additionally, it's been very important to think



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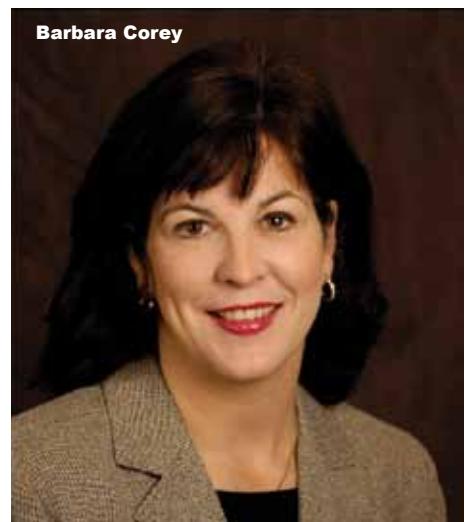
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Barbara Corey

about how to change silos of care to a continuum of care and understanding ACO concepts, making sure that we build a good foundation.

Barbara Corey, Senior Vice President of Managed Care, WellStar: Also, you need to realize that the transition to an ACO really needs to be physician-driven and physician-led. As you look to redesign care, physicians need to be at the center. Data needs to be there for them to effectively do that.

MJ: We've developed a service line infrastructure with physician leaders that can help create linkages. The recognition that physicians need leadership experience and training has been a very important component of our journey. There's been a large emphasis on developing a core group of physicians that have solid business training.

With our new service line infrastructure, we have a recognized leader in key specialty areas. We're supporting each specialty leader with a formal committee structure to support the work that needs to be done to link the continuum of care throughout our organization, from inpatient to outpatient, home health, primary care and other services. The service line infrastructure was part of our strategic development outside of our ACO, and we decided to use that infrastructure to help accelerate the work of our ACO.

BC: I think that's a good example of trying to balance new versus existing infrastructure. Rather than create new leadership within an ACO, we are leveraging a structure we already have within our health system to drive the results of the ACO.

Q: What advice would you offer leaders of hospitals and health systems looking to put together ACO?

CL: It will take more time and energy than you could have imagined. Find early wins and areas, such as improving care, that everyone can rally around. Don't try to avoid conflict. Acknowledge areas where there will be conflicts or when everyone won't win. This is transformational change and it will be messy.

MZ: Hospital leaders need to ask themselves a few questions. First, what are we trying to accomplish in an ACO? Second, is this ACO aligned with our future goals and objectives?

Some hospitals and health systems may feel they need to jump at the new 'hot' thing. However, success in an ACO venture requires an incredible amount of monetary resources and human capital. I think hospitals nationwide should really look at those things before jumping into an ACO. Frankly, an ACO won't work unless all participating players are on the same page. My advice to executives at other hospitals would be to wait on entering into an ACO arrangement until you're ready. The ACO concept doesn't seem to be going away anytime soon.

BC: When it comes to ACOs, pick a place to start and start working on it. You're not going to find a perfect situation to do it, and you're not going to be able to have it all thought out. You need to jump in and start working on the process so your organization can build the necessary skill sets.

DG: Since every organization's circumstance is unique and their marketplace is unique, I'm a little hesitant to give other people advice. In general, we believe that payment reform is going to happen. So you have to decide whether you want to sit on the sidelines and watch it unfold. Or, at what point do you want to try something that is an acceptable risk for your organization? We felt our ACO arrangement was an acceptable risk and that there was probably an advantage with getting experience with a new payment method rather than sitting and watching for the first few years.

Now, some organizations may feel that, in their particular circumstances, they are better off to be an observer for a while. I don't know if that's wrong; they just have to decide that.

Q: What were some of your specific considerations when drafting shared savings agreements?

BC: Primarily we were looking for a shared vision of high quality and efficient healthcare delivery. Beyond that, we were seeking a commitment to aligning goals across the organization. And then, looking downstream, we needed to consider alignment of goals as well as fair distribution of shared savings. It's important to balance new infrastructure needs with delivering shared savings to all ACO participants. Finally, we realize our shared savings agreements need to take into account an overall commitment to high-quality and highly efficient delivery of care across the ACO.

CL: We have tried to build them around the concepts of the "triple aim" as measurements of success and reward. We have also tried to focus on equity and fairness.

DG: We believe that the CMS Pioneer ACO has acceptable risk. It's relatively low risk and if things really went poorly we can get out of it with a 60-day notice. That's virtually unheard of. In general, the Pioneer ACO is set up so that if we can bring the cost trend of the people we are responsible for in at a smaller rate of increase than the national trend, Medicare will share those savings with us.

One of our primary considerations was how we as an ACO would manage risk and share risk. The health systems were more comfortable with this than the physicians. Our physicians were given an option to participate in risk sharing or not. Those more comfortable with taking on risk were given the option to take on up to twice the amount of the baseline risk we allotted for each participating physician in the ACO.

Otherwise, we kept it very simple and said any surplus would be distributed on a proportional basis to all the physicians participating in our ACO.

Q: What has been the biggest challenge of being a part of an ACO so far?

MZ: One of the biggest challenges for our Blue Shield ACO was defining what our quality and financial metrics would look like and how they would be measured. We've worked extensively with Blue Shield to create common definitions for various metrics. We've worked internally to ensure we're focusing on care interventions as well. There are things Blue Shield wants to achieve and there are things we seek to achieve as an ACO; fortunately, we are very aligned in our vision.

BC: One of the biggest challenges has been the overall management and cultural changes involved in looking at things differently and stepping up the level of coordination among various management functions across our system.

It's also been challenging to try and strike a balance between infrastructure needs without adding new infrastructure where you don't need it. We've been trying to take advantage of existing infrastructure and be selective about new infrastructure we need. While we know our ACO plan will require some new infrastructure, we want to be resourceful with what we currently have in place at WellStar.

Another challenge has been to identify the appropriate analytical tools to be effective at population health management and find the most effective tools to help us navigate inpatient and outpatient care coordination.

DG: The hardest part is probably communication and decision making. It's not like our ACO is a single entity in which a single management team can make all the decisions. Trying to communicate with everyone involved has been challenging at times.

CL: To date, we have been successful in developing business models with government and commercial payors. Generation one of our business models are approximately 60 to 70 percent completed. Our clinical models — how we really improve care — are still in the formation stages with some implementation around chronic care management and case management programs. The clinical models are about 20 to 30 percent developed. Implementing the technology needed to pass information from care setting to

care setting, close gaps in care and adhere to practice standards is underway and maybe 20 to 30 percent complete. Engaging our ACO members and/or consumer-patients in improving their well-being is only in the very beginning stages.

The biggest challenge is culturally changing the industry and patients from a historical focus on treatment to a broader focus on prevention, well-being, early detection and treatment. Everyone is going to have to change their thinking and behaviors in some ways for this to work.

Q: How does the Supreme Court's ruling to uphold the Affordable Care Act affect your ACO?

MD: The primary impact for us as an ACO participating in the Medicare Shared Savings Program is that the Court's decision creates more stability with the CMS ACO work within our organization. Before the ruling, we were trying to work through administratively what would happen if the Supreme Court decided to overturn the healthcare law. Would we still have an ACO agreement with CMS if the Court had decided to overturn the PPACA?

For the time being, we have stability and we have some more comfort in decision-making as an organization. However, we recognize that the PPACA is open to legislative changes in the future.

BC: I think regardless of the Supreme Court ruling, the industry has to look at how we redesign ourselves to provide more value to our patients and our communities. We needed to be on the path of healthcare redesign, marching in this direction.

DG: It certainly means that the contractual relationship we have with the Center for Medicare and Medicaid Innovation is unaffected. I suppose if they would have thrown out the entire PPACA, that would have opened up a whole can of worms on the contract we have in place.

However, I think the political environment is such that we don't know what will happen in the next year. What I explain to people in our organization is that politics is not predictable. The regulations and legislations we will have to live with are also not predictable.

What is predictable is that our patients and communities want greater value for healthcare. Our focus is on delivering that greater value for our community. We define this as a safer environment of higher quality with greater customer satisfaction at an acceptable cost.

Q: Where do you see your ACO five years from now?

DG: In the ideal world, we would have converted from one payment methodology that pays for volume to another that pays for value. And we would be achieving the triple aim: doing a better job of preventing illness; a better job of delivering a redesigned patient care experience for sick people; and flattening the rate of cost increases. We would be doing all this while still having a thriving organization that finds a way to be financially sustainable. That's what our ACO intends to achieve. Those are pretty lofty goals and quite difficult to accomplish — but I believe we have a pretty good chance of doing it.

CL: I am hopeful that five years from now our collective focus will be on the reduction of poor health and disease. We will have used the time to build a sustainable healthcare system. ■

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6 Characteristics of High-Performing Healthcare Organizations

By Lindsey Dunn

A common response among healthcare leaders when asked about the impact of the Patient Protection and Affordable Care Act on their organization isn't too surprising given the growing costs of healthcare: Major changes in healthcare delivery were and are coming, regardless of the Supreme Court's decision.

"With the aging population and more people needing healthcare, the need to provide more efficient and effective care would be an issue we'd have to address with or without the ACA," says Quint Studer, founder of the Studer Group. "Healthcare providers have to figure out to improve clinical quality of care at a less costly price."

Nearly every hospital has recognized this to some degree or another and has begun process improvement and other efforts to address efficiency and quality. However, hospitals differ in the degree and urgency of these efforts, and many have a long path of improvement ahead of them, especially in terms of working with physicians around improving clinical quality.

When perception doesn't match reality

A significant obstacle for many hospitals and health systems is that their view of their organization's preparation for reform doesn't necessarily align with reality, as indicated by objective measures.

A recent Studer Group survey of more than 17,000 healthcare leaders in 44 states examined how healthcare leaders rated the care provided at their organization and cross referenced this information with the organization's performance on the HCAHPS survey and CMS' process of care measures. The survey found that leaders' perceptions didn't always match the data, and many hospital leaders overrated the performance of their organization.

This is concerning because, "If you overrate performance, you're not going to improve it," says Mr. Studer. Or rather, if you don't know something is broken, you won't be empowered to fix it.

For example, at hospitals where 75 to 100 percent of leaders reported "quality of care" was something their hospital "did well," patients responding to the HCAHPS survey didn't always agree. These hospitals scored in the 43rd percentile, on average, for the measure "Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)." These same hospitals had an average score of 88.2 on CMS' clinical process of care measures. Hospitals with slightly less confident leadership — 50 to 74 percent of leaders reported "doing well"

— performed better on core measures (94.0 average score).

Transparency may require cultural change

This disconnect highlights the importance of using objective data to drive and monitor performance improvement, rather than relying on perception. This may require a culture change within organizations as, historically, hospitals have been slow to embrace transparency.

"For years, healthcare providers so worried about what gets out in public, what people may think and litigation that they sometimes held tight clinical outcomes and patient safety data," says Mr. Studer. "As this data is released and more available to the public, leaders must be willing to own that data and get aggressive about putting in place practices to improve efficiency and quality."

So what are some of those practices that can move a hospital toward transparency and high performance? Mr. Studer says it's not about the specific program but rather the level of accountability in an organization's culture.

"Healthcare providers tend to grab programs or buzzwords; They're good programs but they don't know how to effectively execute them," he says. "Take Lean or process improvement — we're a huge believer in both at Studer. But, unless the organization changes certain core things, such as its leadership training and an evaluation system to hold people accountable, the organization won't maintain high performance."

According to the Studer survey, six specific characteristics of healthcare organizations were correlated with a positive affect on HCAHPS results.

1. Doesn't tolerate low performers. Organizations with leaders who reported a high percentage of low performers had lower HCAHPS results. Accordingly, hospital leadership must put into place hiring and performance evaluation tactics that rid the organization of low performers who "sabotage excellence," says to Mr. Studer.

2. Alignment among senior leaders. A lack of alignment at the senior leadership level negatively affects HCAHPS results. For example, the survey found that even senior leaders within an organization varied in terms of the level of concern they had for their organization's future and the urgency with which their hospital should adapt.

"If senior leaders don't see the environment the same way, you don't get the execution you need to see results," says Mr. Studer.



3. Effective leadership training. Positive perception of leadership training was positively correlated with HCAHPS scores. That is, hospitals where leaders felt they were well prepared for their roles had higher HCAHPS results, on average, than organizations where leaders gave their training lower marks.

4. Effective leadership evaluation systems. Hospitals where leaders reported effective evaluation systems had higher HCAHPS scores, on average, than those that lacked strong leadership accountability systems.

"Hospitals with an evaluation tool that holds people accountable for performance provide better patient care," says Mr. Studer.

5. Consistent leadership. High ratings on consistency of leadership positively affected HCAHPS results. Consistency requires alignment among leaders as well as low turnover amongst these leaders, according to Mr. Studer.

6. Standardization of best practices. Hospitals that received high ratings by their leaders for implementing and standardizing best practices also had higher HCAHPS results, on average.

According to the survey report, "Identifying best practices really does not seem to be the problem. The problem is moving best practices. When they move best practices, they have positive outcomes."

Leaders looking to prepare their organizations for a future of reform and pay-for-performance should worry less about the next process improvement "buzzword" and instead focus on cultivating a culture of accountability that demonstrates these six characteristics. ■

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Healthcare M&A Activity: Key Trends for Transactions, Valuation of Ambulatory Services

By Jason Ruchaber, CFA, ASA, Partner, HealthCare Appraisers

Healthcare today is marked by nearly unprecedented levels of change. From healthcare reform to reimbursement reductions to new payment models, there seem to be fewer and fewer constants in healthcare delivery. These changes have brought significant challenges for organizations as well as opportunities. Some providers struggle with both the human and financial capital needed to prepare their organizations for the next era of healthcare delivery, while others, who are more advanced, are seeking out partnerships to expand their footprint and improve economies of scale. As a result, the past year has been very active for the healthcare merger and acquisition market.

In 2011, 980 healthcare mergers and acquisitions were recorded, worth \$227.4 billion, up 11 percent from \$205.6 billion in 2010, according to an Irving Levin Associates report. In the first quarter of 2012, 249 deals were recorded for a total of \$34 billion, and the second quarter experienced 251 deals worth \$61.2 billion. While hospital and health system M&A activity has been active and should be followed by healthcare leaders, it is also important healthcare leaders understand some of the key M&A trends for ambulatory subsectors as well. These sectors will increasingly overlap with hospitals' and health systems' interests. Here are some trends HealthCare Appraisers is seeing in terms of M&A activity among the physician practice, ambulatory surgery center, urgent care, imaging and oncology subsectors.

Physician practices

Physicians are preparing for a future where they will be required to provide care for more patients with less reimbursement, and are opting to give up their independence to gain the income stability afforded by hospital employment. Hospitals focus on physician alignment and integration to gain competitive advantages, compliment their services and drive inpatient volume. Practice acquisition and subsequent integration is also critical to hospitals' overall strategy to provide continuity of care for patients. Some trends to note in for this subsector include:

Increase in smaller practice acquisitions. We have observed an increase in small — one- to two- physician — practice acquisitions. These practices generally command little to no intangible value and are mostly focused on post-acquisition compensation to the physician(s). This makes them easier for hospitals to acquire, and the growing challenge of operating independently is compelling physicians to align themselves with a hospital in order to access financial and other resources needed to practice medicine.

Large groups holding out. Though many large physician groups have been acquired over the last couple of years, and though these groups continue to be of strategic interest to health systems, health plans and even private equity firms, not all large groups are interested in making themselves available for acquisition. Unlike smaller practices, many of these groups remain economically viable, earn good compensation and maintain strong reputations in their communities, making hospital alignment less necessary. Additionally, because larger physician practices do often command significant intangible value, the transactional process is usually more complex and time consuming.

Shift away from cardiology. During 2010 and 2011, cardiology was of significant strategic importance to hospitals and health systems, and competition for the acquisition and subsequent employment of cardiologists remained at very high levels throughout these years. By late 2011 most of the independent cardiology groups had been acquired, and hospitals began to transition away from their focus on this specialty. While there is still some acquisition activity relating to cardiology, hospitals have shifted their acquisition focus to family practices, internal medicine and primary care groups, as well as surgical specialties such as gastroenterology and orthopedics.

Decrease in obstetrics/gynecology. In 2010, there was a strong demand for OB/GYN practices. Like cardiology, this demand decreased in 2011. Acquisitions are still occurring, but much less frequently and usually involve smaller, independent

practices struggling with a number of factors including exceptionally high malpractice premiums.

Challenging valuation models. The valuation models for physician practices continue to be a challenging and hotly debated topic in the valuation community, specifically relating to when and how to quantify intangible value for practices. We have observed an increase in problematic models due to valuation firms improperly assigning value to economic benefits or applying overly aggressive assumptions. Conversely, we continue to see arguments advanced by appraisers that suggest physician practices have little or no intangible value. We continue to believe that more balanced stance on practice appraisal is the correct position, and it is imperative for physicians and hospitals to understand the economic reality of the deal and the regulatory environment in which they operate. This includes focusing on reasonable and sustainable purchase prices and compensation models that do not violate the regulatory framework for these transactions, and that will benefit both parties for the long term.

Robust compensation models. We have noted more robust — and in some cases overly robust — compensation models tied to physician practice acquisitions. This is likely attributable to physician supply and demand, as well as limitations on the capital resources available to pursue acquisitions. In this environment there is a higher propensity for acquisitions to be purely fixed asset purchases followed by a more robust compensation model. Because of the direct link between practice purchase price and post-acquisition physician compensation, increases in compensation may render the business valuation exercise unnecessary as any intangible value is consumed by the post-acquisition employment model.

Ambulatory surgery centers

Current acquisition activity in this subsector is driven by a number of factors:

Physician employment by hospitals. The employment of physicians, whether in

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surgical or non-surgical specialties, by hospitals placed downward pressure on ASC multiples because of the increased risk that surgical volume would either become unsustainable or decrease due to downstream referral patterns. We have noted that as surgical volume growth slows and risk increases, physicians become more interested in selling controlling interest in their surgery center to a hospital, health system or ASC management and development company.

Conversion of ASCs to HOPDs. We have observed hospitals increasingly seeking to fully acquire any ASC in which they had an ownership interest and converting the surgery center to a hospital outpatient department. By purchasing surgery centers in full, hospitals are able to increase their OR capacity to further support employed physicians and see an immediate increase in reimbursement by converting the ASC to an HOPD.

Supply and demand. While valuation multiples may have been lowered due to the risk/uncertainty caused by employment of physicians and the associated declining volumes, this downward pressure on pricing is partially offset by the increased demand of ASC acquisitions. We observed physicians pursuing a sale of their controlling interest in an ASC to take advantage of this increase in valuation multiples. Demand also increased as physician de novo development of ASCs declined due to uncertainty in the marketplace and a diminished supply of investors.

Buying preferable to building. While we have observed some hospital de novo development of ASCs, hospitals appear more likely, especially in certificate of need states, to pursue the acquisition of an existing ASC rather than take on the risk of building a new center. In some instances, we observed hospitals in CON states acquiring ASCs for the purpose of transferring the surgery center's CON for its operating rooms to another existing hospital facility to expand capacity.

Urgent care centers

We have observed strong acquisition activity in the urgent care center market, driven by two key factors:

Gateway to the hospital. Hospitals are aggressively pursuing and acquiring urgent care centers located throughout their service area as

many hospitals identified urgent care centers as a gateway to influence patient behavior and direct patients into the hospital for follow-up care. As more patients sought out urgent care centers as an alternative to crowded emergency rooms, hospitals worked to acquire these facilities and extend their footprint throughout their communities.

Increased competition. Hospitals are facing increased competition for the urgent care as pharmacies such as Walgreens and even some supermarkets are employing nurse practitioners to provide urgent care-related services. As competition grows, hospital will acquire urgent care centers to remain competitive in the market while supporting the hospital's mission of providing continuity of care for patients.

Imaging centers

There has been significant acquisition activity in the imaging center subsector driven by a number of factors:

Shrinking referral base. We have observed the referral bases for imaging centers drying up as more physicians who used the centers became hospital employees. Imaging centers were typically sustainable when faced with just competition from practices with in-office imaging capability, but hospital employment of physicians significantly reduced imaging center volume and turned once profitable centers into financially distressed facilities.

Support of hospital strategies. From a valuation perspective, acquiring imaging centers matches hospital strategies of physician employment and continuity of care for patients. As hospitals employed more physicians, they grew their pool of physicians ordering diagnostic images. When hospitals lacked sufficient capacity with their existing equipment, or if they were in states with strict certificate of need laws concerning building new facilities or large capital investments, an acquisition presented an opportunity to create capacity for physician referrals and patient scheduling.

Low multiples. We have noted fairly significant downward pressure on multiples in the imaging space. In many cases we're seeing struggling centers that can no longer operate in an independent fashion. Imaging is not expected to see an increase in reimbursement in the near fu-

ture, contributing to the low multiples that make for good acquisition activity.

Cancer centers

We have observed strong acquisition activity in the radiation therapy cancer center market driven by a number of factors:

Hospital employment of primary care physicians. Most recent hospital acquisition activity has been driven by the increasing trend of hospital employment of physicians. This included the acquisition of radiation therapy cancer centers. As hospitals employed more primary care physicians, these physicians needed a destination for referred patients to receive radiation therapy. If a hospital desired to provide this service to these patients but either did not operate any cancer centers or lacked the capacity to treat patients, the hospital either acquired or built/expanded a facility to create capacity. We have observed many hospitals choosing the acquisition route over construction as the means of expanding its radiation therapy services.

Focus on the technical business. We have noted an increase in the acquisition of radiation therapy centers and linear accelerators where hospitals only bought the technical business of the center and did not acquire the professional practice of the radiation therapists or medical oncologists using the center and LINAC.

Hospital employment of radiation therapists and medical oncologists. We have noted the decision by hospitals to acquire a radiation therapy business and LINAC was frequently coupled with a desire to employ radiation therapists and medical oncologists who were part of the oncology practice that owned or utilized the center or LINAC.

Challenging CON laws. Some states have certificate of need requirements for large capital investments such as a LINAC, and these requirements may preclude or challenge a hospital from investing in a new LINAC. In such areas where it is difficult to put a new LINAC into service, hospitals viewed the acquisition of the technology as the only option or a more appealing choice to the often lengthy, time-consuming and expensive CON process. ■



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5 Observations on the State of Hospital Credit Markets (continued from page 1)

For hospitals and health systems, the key rates within the tax-exempt market — the Municipal Market Data rate, the Securities Industry and Financial Markets Association municipal swap index and others — have also been exceptionally low, which makes borrowing much cheaper. On July 24, the 30-year MMD hit a record-low of 2.8 percent.

Steve Kennedy, senior vice president and investment banker for Lancaster Pollard, says there are a couple of indices that are very indicative of the current interest rate climate. For healthcare providers rated “A” or higher by credit rating agencies, interest rates have been most advantageous, and even hospitals rated “BBB” or higher — which are at the lower end of the “investment grade” spectrum — are able to secure capital at relatively favorable yields.

For example, over the past year, 30-year “A”-rated healthcare yields are down more than 140 basis points from 5.75 percent in 2011 to 4.33 percent this year. Thirty-year “BBB”-rated healthcare yields have also experienced a similar decline, down from 6.53 percent last year to 5.17 percent over the same time period.

“The movement of both 30-year curves has enabled investment-grade healthcare credits to experience significantly lower fixed-rate borrowing costs,” Mr. Kennedy says. “Additionally, what the curves do not necessarily communicate is that healthcare borrowers are now enjoying greater access to fixed-rate markets, particularly when compared to the municipal market just a couple years ago.”

Non-profit hospitals have historically concentrated most of their long-term borrowings in the tax-exempt markets, where rates tend to be lower due to the tax advantages provided to investors of tax-exempt papers. However, hospital CFOs should also analyze current trends in the taxable, or corporate, bond market — a market significantly larger than the tax-exempt debt universe.

Pierre Bogacz, managing director and co-founder of HFA Partners, points out that when it comes to variable rate debt, the advantage has shrunk considerably. For example, the SIFMA seven-day rate (for tax-exempt bonds) is currently 0.16 percent while the one-month Libor rate (for taxable bonds) is 0.25 percent: On a \$50 million borrowing, this represents annual savings of only \$4,500, something Mr. Bogacz says is hardly worth the costs of getting a tax-exemption.

“The record-low rates have really removed the advantage of the tax exemption from the short end of the yield curve,” he says. “But when rates go back up, the savings will come back, so it doesn’t mean hospitals should abandon tax-exempt debt. Also, on the longer end of the yield curve, tax-exempt fixed-rate debt is still generally cheaper than borrowing on a taxable basis.”

2. Credit spreads are still high. Mr. Bogacz notes that overall, for hospitals wanting to go to the debt markets, the climate is very favorable. However, while benchmark rates like MMD, SIFMA and Libor are at record lows, credit spreads for healthcare have remained relatively high. A credit spread is the difference between the yield on an “AAA”-rated general obligation bond and what a borrower rated less than “AAA” will pay. The lower the borrower’s rating, the higher the credit spread. The high credit spreads for lower investment-grade hospitals have negated some of the savings that can be had from lower rates, he says.

“While credit spreads have come down in the last few months due to limited supply of hospital bonds, credit spreads are still very high compared to 10 years ago,” Mr. Bogacz says. “That tells us that investors, particularly institutional investors who buy bonds in the primary and secondary markets, still think hospitals involve significant risk.”

3. Larger, higher-rated hospitals and health systems tend to have more borrowing power, but smaller hospitals are still active. Generally, larger hospitals and health systems are more highly rated and enjoy better access to the debt markets. This is partially due to “strength in numbers,” as large borrowers typically enjoy better margins and less variability in financial performance — which rating agencies and investors prefer.

“If you’re a hospital rated ‘AA,’ and you’re going to the market, you’re looking at a spread of around 75 basis points,” Mr. Bogacz says. “And you’re also going to have access to additional structures and ways to tap into the debt market that a smaller hospital will not have access to.”

Paul Storiola, former CFO of Robert Wood Johnson University Hospital in New Brunswick, N.J., says two years ago, the hospital completed a refinancing. RWJUH’s strong credit rating — “A-” at the time from Standard & Poor’s — made access to the debt market easier. He adds that since then, S&P has upgraded the hospital’s rating from “A-” to “A.”

However, Mr. Kennedy explains that smaller hospitals, which usually have lower credit ratings due to their generally more challenged credit profile, still have been active in the credit markets. Some successful smaller hospitals are carefully focusing on maintaining solid liquidity — high days cash on hand and a favorable cash-to-debt ratio — through effective balance sheet management in order to access the debt markets.

“The municipal investor market’s appetite for healthcare paper has grown notably in 2012 as investors search for yield,” Mr. Kennedy says. “This has enabled smaller hospitals, which tend to be lower-rated or nonrated, to tap into investors’ growing demand for lower-rated credits, assuming the hospitals exhibit strong profitability, liquidity and capital structure ratios.”

According to S&P’s 2010 credit report, the following are median ratios for small hospitals rated “BBB”:

- Operating margin: 3.3 percent
- Excess margin: 4 percent
- Days cash on hand: 176
- Cushion ratio: 12x
- Cash-to-debt ratio: 115.2 percent
- Historical debt service coverage ratio: 3.1x
- Maximum annual debt service/revenues: 3.9x
- Debt-to-capitalization ratio: 37.7 percent
- Average age of plant: 7.8 years

4. Liquidity and an attractive business plan are both important to credit rating agencies. Whether a hospital is looking to refinance existing debt or issue “new money” debt, its credit rating — either publicly rated or internally rated by investors — is critical to its cost of funds. S&P, Moody’s Investors Service and Fitch Ratings issue credit ratings in the hospital and healthcare markets, and Mr. Bogacz says there are several areas hospital CFOs and executive teams can focus on to lower their borrowing cost.

Cash is always king, so hospitals should try to preserve and accumulate liquidity — this means cash and investments should be at above-median figures, even if this means taking on more debt to conserve cash. “Boosting liquidity is the quickest way to improve ratings,” Mr. Bogacz says. “But of course that’s easier said than done.”

Mr. Storiale adds that when hospital executive teams meet with credit rating agencies, they need to explain every component of the hospital's business and why the hospital is in a good position to succeed. "Credit rating agencies look for a clear indication of where you're going," Mr. Storiale says. "In many cases, if the numbers may not be where they would like to see them but the plan is good, they'll listen."

5. Bank direct placements are on the rise.

Bank direct placements are like publicly-sold bonds in that they are issued for new money or refunding purposes and can be tax-exempt. However, they are sold directly to a single bondholder, such as a bank, that holds the bonds to maturity. In the past three to four years, Mr. Bogacz has seen a huge increase in bank direct placements because they are seen as more cost-effective than public offerings. "In situations where they work, they can be a lot of cheaper," he says. "Since there is only one investor, there is no need to go through the expense of hiring a bond underwriter as you would with a traditional public offering."

According to Thomson Reuters, the trend is clear. In 2011, banks loaned roughly \$2.9 billion in private healthcare lending compared with \$503 million in 2010 — a difference of almost six times.

Mr. Kennedy cautions that while some investment-grade healthcare providers are leveraging direct placements to avoid some of the risks associated with letter-of-credit backed variable rate demand bonds, hospital leadership must keep in mind that bank-related debt is typically short-term in nature.

For example, while a direct placement may amortize over 25 years, the term is typically anywhere from three to 10 years. "If a hospital leadership team wants to eliminate the rate reset risk and refinance risk, true fixed-rate debt financing — whether via an unenhanced offering or an agency-enhanced offering like FHA mortgage insurance — should be considered," Mr. Kennedy says.

Hospitals can also combine debt structures, using bank-related short-term debt for the retail component of an offering and truly fixed-rate debt for the longer maturities. "It's important for hospitals to keep their exposure to bank-related debt below the system's total cash and short-term fixed income investments," Mr. Kennedy says. "Using the hospital's liquidity position as a natural hedge against interest rate and refinance risk is a nice starting point to determine how much bank-related debt exposure is prudent for a hospital."

Hospitals and health systems that are looking into bank direct placements should also be aware that like any financing instruments, all eggs should not be placed into one basket. "A bank direct placement is like a loan," Mr. Bogacz says. "Unlike with a letter of credit, you don't have put risk, but you may still have renewal risk, so it's important to make sure your lenders will be around. We recommend hospitals build relationships with more than one bank." ■

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Moody's: Supreme Court Ruling "Credit Neutral" for Hospitals

By Bob Herman

A report from Moody's Investors Service determined that the Supreme Court's ruling to uphold most of the Patient Protection and Affordable Care Act is a "credit neutral" for non-profit and for-profit acute-care hospitals.

At for-profit hospital operators such as Nashville, Tenn.-based Hospital Corporation of America, Franklin, Tenn.-based Community Health Systems, Dallas-based Tenet Healthcare, Brentwood, Tenn.-based LifePoint Hospitals and others, Moody's analysts believe the expansion of healthcare coverage to millions of Americans will lessen their exposure to bad debts, "which in turn will improve margins and cash flow."

HCA, CHS, Tenet and LifePoint stand to benefit the most because they are the largest rated acute-care hospital operators by revenue. For-profit hospital operators, in general, will see more positive impacts because of their larger capital structure. "However, the ultimate relative impact on any

individual company would depend on a number of factors, including volumes, patient mix, demographic changes and service mix," the report said.

Non-profit hospitals are expected to see similar benefits of the insurance expansion, and other aspects of the law — such as the extension of coverage to dependent children up to 26 years of age, the Medicaid expansion and state health insurance exchanges — are all expected to be positive credit features.

However, non-profit and for-profit hospitals will still face reductions to Medicare reimbursements. The PPACA calls for \$150 billion in Medicare payment cuts to hospitals over the next decade, and there will also be cuts of \$14 billion to Medicaid disproportionate share payments. This will offset some of the benefit of lower bad debt expenses, according to the report, and it will particularly impact safety-net hospitals that see a disproportionately higher amount of poor patients. ■

Feds Propose Rules to Control Collection Practices at Non-Profit Hospitals

By Molly Gamble

The U.S. Department of Treasury has proposed rules to protect patients from abusive collection practices at charitable hospitals.

Here are some key elements of the department's proposed regulations:

- Tax-exempt hospitals must establish a policy for financial assistance, explain its criteria to patients and provide clear instructions on how to apply for it.
- Hospitals must also publicize the financial assistance policies to ensure patients and community members are aware of the available aid.

- Tax-exempt hospitals are prohibited from certain collection methods, such as reporting a debt to a credit agency or garnishing wages, until it makes a "reasonable effort" to determine whether that individual is eligible for financial assistance. As part of this rule, hospitals must give patients a total of 240 days to submit applications for financial assistance.
- Hospitals cannot charge individuals eligible for its financial assistance more for medically necessary care than the amounts generally billed to insured individuals. If the person is eligible for aid, the hospital must refund any excess payments already made.

- Debt collection activities in emergency departments or other hospital venues where collection activities could interfere with treatment is prohibited.

"In recent months, we have heard concerns about aggressive hospital debt collection activities, including allowing debt collectors to pursue collections in emergency rooms," Acting Assistance Secretary for Tax Policy Emily McMahon said in a June news release from the Department of the Treasury. "These practices jeopardize patient care, and our proposed rules will help ensure they don't happen in charitable hospitals." ■

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Adding Value to Healthcare by Eliminating Waste: Q&A With Virginia Mason Medical Center CEO Dr. Gary Kaplan

By Kathleen Roney

Gary Kaplan, MD, has been chairman and CEO of Virginia Mason Medical Center in Seattle since 2000. Dr. Kaplan is also a practicing internal medicine specialist at Virginia Mason's clinic in Kirkland, a Seattle suburb. During Dr. Kaplan's tenure as chairman and CEO, Virginia Mason has received significant national and international recognition for its efforts to transform healthcare. Awards and distinctions include Top Hospital of the Decade by The Leapfrog Group, 2012 Top Hospital — for the sixth consecutive year — and a grade "A" patient safety rating by The Leapfrog Group, a 2012 Distinguished Hospital for Clinical Excellence and Patient Safety Excellence Award from HealthGrades and a 2012 America's 100 Best Specialty Excellence Award for Overall Cardiac and Gastrointestinal Care from HealthGrades.

In 2002, Virginia Mason embarked on an ambitious program to adopt the principles of the Toyota Production System as its management system. The Virginia Mason Production System, or VMPS, is a system-wide management system that improves patient safety and quality, reduces cost and the burden of work for the healthcare workforce.

Here, Dr. Kaplan discusses how VMPS helps Virginia Mason eliminate waste — one of the biggest challenges he feels the healthcare industry faces today — to focus on the patient, his perspective on partnerships and how leadership means going against the grain to make the tough calls.

Question: Hospitals pursue partnerships or mergers for a variety of reasons. In February, Virginia Mason and Kirkland, Wash.-based EvergreenHealth approved a strategic partnership. How did you approach that partnership?

Dr. Gary Kaplan: While it is not our first partnership, the EvergreenHealth partnership is important because it was developed and executed at a time when many others, including some in the market, were consolidating or merging to get bigger, grow market share and enhance pricing power.

Our partnership with Evergreen is predicated on a shared vision and shared goals as well as a belief that a thriving respectful partnership between like-minded organizations makes more sense than a medical arms race.

Q: What would be your advice for other CEOs to ensure a beneficial partnership?

GK: I would advise other hospital CEOs to remember that culture and shared values are just as important as other considerations, such as size and market power, for a potential partner.

We are supportive of a collaborative approach that doesn't need governance or a balance sheet merger to succeed. I am not saying those things are inherently bad, but I am saying that the recent rapid market consolidation is not necessarily in the best interest of patients and communities. Partnerships need to be complementary to be successful, and our partnerships are great examples of that.

Q: What challenges currently face Virginia Mason Medical Center? How do those compare to current national challenges?

GK: Our greatest challenge is the same challenge that everyone faces, although they may not all agree it is the greatest challenge. For us it is: How do we create even greater value in our marketplace? We do that here by eliminating waste. We think that [waste] is an enormous problem. That which adds no value is how we define waste. Donald Berwick, the former administrator of CMS and founder, former president and CEO of the Institute for Healthcare Improvement, called waste the "quality dimension of our time." He is a quality guru, and over the past 20 years, he has come to see how [healthcare] can focus on eliminating waste and how it will add tremendous quality and safety to our healthcare processes and outcomes.

Even though the challenge of waste continues, we feel we are in a good position. Our staff is trained to focus on eliminating waste every day; it is a mindset that exists among our staff. Some estimates say that 30 to 40 percent of what we spend on healthcare today adds no value. When you think about that estimate, it is as much as a trillion dollars of waste, which includes all categories of healthcare: administrative, clinical decision making, overuse of diagnostic and therapeutic interventions, inventory, facilities and more. The areas that may be adding no value are huge opportunities for us to improve.



Q: You mentioned that the Virginia Mason staff is trained to think about eliminating waste every day. How have you made a "waste elimination" mindset a fundamental part of the hospital?

GK: It goes back to the strategic plan we developed around 2001, which helped to clarify the question: Who is our customer? Everyone says the customer is the patient, but in reality that is not always the behavior of those of us in healthcare. We have designed our systems and processes around us — the physicians and nurses. Instead, at Virginia Mason we have focused on developing systems and processes around the patients. That led us to our core vision and core strategy. Basically, we bet the farm on a quality strategy more than 10 years ago. We wanted our core business strategy to be quality rather than size and market power, and in doing so, to create value for our patients and our communities.

The way we chose to do that was by adopting Toyota Production System principles. We have been applying it consistently longer than anyone in healthcare. Every one of our employees is trained in its methods. Several thousand members of our staff have participated in improvement events over the past decade. It is a way of life — it is our philosophy and management system. We focus on the belief that we can mistake-proof our processes and get closer to zero defects in the healthcare we deliver to our patients by eliminating waste. It has been a remarkable 10 years centering on this quality strategy and applying the specific methods that we borrowed from manufacturing.

Q: You mentioned that a quality focus and the Toyota Production System influenced Virginia Mason's philosophy. How do those elements of your philosophy inform your goals for Virginia Mason or where you'd like to see the medical center progress?

GK: Our vision is to be a quality leader not just in Seattle but everywhere. That is what we aspire to be. We also want to help transform healthcare. The way we have chosen to do that is by striving to create a perfect patient experience at Virginia Mason — every patient, every time. We strive to show a great patient experience is possible without building unnecessary facilities and having dominant market share. The patient should not have to wait in the emergency room or on the phone. We strive to give the patient everything they need and only what they need. We want to

show that a hospital can succeed in patient experience and thrive economically. Our aspirations are about our patients and about our community.

Q: Can you share one piece of advice or one lesson you've learned throughout your career?

GK: I would start by saying that it is important for leaders to have passion. Leaders need to care and to feel emotionally connected with their work and their vision. They need to share that passion and inspire others by appealing both to the head and the heart.

Healthcare today is hard work and it is complex. As senior leaders, we have a responsibility to inspire our people and lead our people, but we need to appeal both to the intellect as well as to the emotions or heart of our people. We need to

never lose sight of why we went into medicine.

For me that is part of who I am; I am passionate about Virginia Mason's vision and what we are working on. I have come to see over time that the combination of intellect and passion will best inspire others to achieve what is necessary for large scale change at an organization.

A lot of individuals make rigorous intellectual arguments but can't move organizations forward. Just appealing to the heart without a rational and intellectual foundation is also not the ultimate or best leadership approach. You need both.

Q: Who has most inspired your personal leadership style? What did he/she teach you?

GK: There are many individuals I have been very fortunate to have as mentors. I have also tried to be a student of leadership, constantly watching others and learning every step of the way.

However, my father heavily inspired my personal style. He was a businessman and still is at age 87. I grew up working in his hardware store. I learned about customers and how listening carefully, maintaining a sense of humor and having optimism are really important tenets in leading either a small business or a healthcare enterprise.

Q: Do you have any personal routines or guideposts when you come to difficult decisions? How do you handle that pressure and come out with a no-regrets answer?

GK: I think it starts by listening carefully rather than having my mind made up and shutting down. I think that may be a pitfall that many leaders fall into. Another would be doing my homework [before a decision]. Leadership is hard work, and you need to take it seriously, which means doing research, talking to many stakeholders and listening to diverse viewpoints. I want to surround myself with people who present varied points of view and not those that just agree with me.

If a discussion is going in a certain direction and even if I agree with it, I will ask for someone to present an opposite point of view so we can hear it and make sure we present all alternatives. After we review and make sure there is fair process for all stakeholders, someone has to make the call. I try not to shy away from making those decisions. You have to make sure that a decision is fairly communicated and you can execute the strategy or tactic.

I also reserve the right to be smarter today than I was yesterday. That may mean we change our minds. When all is said and done leaders today need to have what I think many call managerial courage. We need to be able to sometimes go against the grain, go against the flow and make tough calls. ■

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5 Cornerstones of a Culture of Compliance for Hospitals

By Molly Gamble

The fight against healthcare fraud is a top priority for the government today, as evidenced by harsher federal sentencing guidelines for healthcare fraud, an increase in the number of Medicare Fraud Strike Force teams and federal fraud prevention programs such as the Medicare and Medicaid Recovery Audit Contractor programs.

The dollar amounts of Medicare RAC recoveries have escalated throughout the past few years. In the first quarter of fiscal year 2012, RACs took back \$397.8 million in overpayments. That is roughly half the amount RACs collected in all of fiscal year 2011 (\$797.4 million) and more than 10 times the recoveries collected in FY 2010 (\$75.4 million).

Enhanced efforts and increased federal funding for fraud prevention have led to significant returns for the government. For instance, in fiscal year 2011, the government recovered approximately \$2.4 billion through civil healthcare fraud cases brought under the False Claims Act. The government has also reached other milestones in fraud prevention, such as the takedown of a \$452 million Medicare fraud scheme in May.

"As a general statement, government enforcement is becoming more rigorous as time progresses. The government enforcement budget has climbed dramatically in the past several years, with a substantial increase of tens of millions of dollars going toward healthcare fraud enforcement," says David Pivnick, JD, a lawyer with McGuireWoods in Chicago.

The rise of RACs

The Medicare Recovery Audit Contractor program went into effect with the Tax Relief and Health Care Act of 2006. RACs identify overpayments and underpayments to providers in all 50 states, and contractors are paid on a contingency fee basis, receiving a percentage of the improper overpayments they recoup. RACs may conduct medical reviews and examine claims from the past three years for hospital inpatient and outpatient services, as well as physician, nursing facility, ambulance, laboratory and durable medical equipment services.

The breadth of the audits expanded this year, as well. CMS took many of its key findings from the Medicare RAC program to create and implement the Medicaid Recovery Audit Contractor program, which was included in the Patient Protection and Affordable Care Act. States were required to establish programs by the beginning of 2011, in which they contracted with one or more RACs to review claims submitted to state Medicaid plans. The government expects Medicaid RACs to save \$2.1 billion over five years.

Most hospitals have experienced Medicare RAC audits. In the first quarter of FY 2012, about 87 percent of hospitals experienced RAC activity, according to the American Hospital Association's RACTrac Survey. Additionally, the scope of RAC audits seems to be expanding: Hospitals reported 447,523 medical record requests from RACs through the first quarter of 2012 compared with 306,349 in the third quarter of 2011.

Attorneys with McGuireWoods say hospitals should be prepared for RAC activity. "Larger systems should anticipate a RAC audit in the same way they anticipate an accreditation survey," says Holly Carnell, JD, lawyer with McGuireWoods.

Cornerstones to developing a culture of compliance

The government's stringent focus on fraud, abuse and waste — and the increasing role of RACs — has implications for hospitals and their traditional understanding of compliance.

"Having a compliance plan sitting on the bookshelf gathering dust is simply not enough," says Ms. Carnell. "Every individual who is involved in operating a hospital and health system has to be fully committed to compliance."

Hospitals that promote and adopt an active culture of compliance rather than a passive compliance plan may be able to more effectively protect themselves against fraud and abuse. Here are five key steps to creating a culture of compliance at a hospital.

1. Conduct internal billing and coding audits. Internal billing and coding audits should generally be performed twice per year and periodically with outside auditors to ensure compliance with requirements for Medicare, Medicaid and third party payors, according to Scott Becker, JD, CPA, a partner with McGuireWoods. Specifically, internal audits may focus on areas in which there is high concentration of procedures or outlier Medicare payments to determine if the claims are necessary and services were rendered. The latter can be determined by examining the hospital's internal clinical documentation.

U.S. Attorney Jerry E. Martin said Maury Regional Medical Center in Columbia, Tenn., should be commended for the manner in which it disclosed billing issues once they came to light through the hospital's compliance program.

An internal audit identified improper claims for ambulance services from 2004 through 2009. Claims in question included those for ambulances that were not medically necessary, for which a physician certification statement was not obtained or that were billed with incorrect mileage units. The hospital recently reached a \$3.6 million False Claims settlement with the government after voluntarily reporting the billing discrepancies.

2. Train and educate employees. Hospital management should conduct periodic educational sessions for employees on compliance. This information should not be reserved for a one-time training session with new hires. Rather, hospital staff and physicians should be refreshed on the cornerstones of compliance and how they should report potential billing errors or fraud. Frequent education and discussions on legal compliance is one of the major differentiators between an active culture of compliance and a passive compliance plan.

3. Designate a compliance officer. This high-level official should be extensively involved in all matters of the hospital's compliance discussions and initiatives. The compliance officer should have direct lines of communication to the hospital CEO and governing body. Depending on the size of the hospital, the compliance officer may be a full-time job in itself, or the responsibilities may be added to an existing management position.

It's a bad sign when the organization's compliance officer isn't visible to staff, or isn't an active participant in the hospital's legal discussions, according to Mr. Becker. "You need to be sure you're being open and honest with your compliance officer and generally include them in compliance discussions."

4. Respond to detected offenses appropriately. When a hospital employee reports potential misconduct, noncompliance or fraudulent activity, hospital management needs to respond promptly and appropriately. "The appropriate response is to thank the individual and let them know you'll investigate their claim," says Ms. Carnell.

Hospitals do not necessarily owe the reporting employee further information in terms of investigation or audit findings, but hospitals should keep

in mind that the first people to report misconduct may very well be the government's first witness for a federal investigation.

A hospital's approach in handling compliance concerns today can affect how employees report misconduct in the future. Employees who are dissatisfied with their employer's response may be more likely to file whistleblower suits with the government.

"People bring claims to the government for a variety of reasons. Some of them just feel that they are not being heard when they raise complaints internally," says Mr. Pivnick. "Making sure you conduct a detailed investigation and making sure you take complaints seriously can be helpful in avoiding future claims."

5. Maintain open communication. Internal investigations conducted by legal counsel can breed mistrust and defensive behavior among hospital executives and employees, but open communication is crucial for employees to come forward with complaints or speak up if something seems wrong.

"Some people are very defensive. They feel their job is on the line. During an internal investigation, certain executives feel it's their job to defend the organization and make sure no wrongful behavior is uncovered, even though we're on their side," says Ms. Carnell. "Being able to foster an environment of trust in any internal investigation is key to getting all the facts and working toward a resolution." ■

Congress Asks GAO: Are Medicare Audit Contractors Duplicative?

By Bob Herman

In a letter to the Government Accountability Office, a bipartisan group of Senators and Representatives asked for a study on the effectiveness and coordination among the different Medicare contractors within CMS.

Sens. Orrin Hatch (R-Utah), Max Baucus (D-Mont.) and nine other Congressmen requested a study that zeros in on the five types of Medicare contractors: Medicare Administrative Contractors, Medicare Recovery Auditors, Zone Program Integrity Contractors, Program Safeguard Contractors and Comprehensive Error Rate

Testing Review Contractors. All of these contractors are tasked with making sure Medicare pays claims accurately to hospitals, physicians and other providers and catching any fraud and abuse.

Specifically, the group wants the GAO to answer four main questions:

1. What process does CMS use to determine whether the contractors' audit criteria and methodologies are valid, clear and consistent?
2. How does CMS coordinate among these contractors to ensure their interactions with providers are not duplicative?
3. What are the reasons for requesting that similar information be submitted to multiple contractors, and is CMS taking steps to limit duplicative audits?
4. Does CMS have a strategic plan to coordinate and oversee all of its audit activities and, if so, how is that plan implemented and overseen? ■

HCA: U.S. Attorney's Office Requested Information on Medical Necessity of Interventional Cardiology Services

By Sabrina Rodak

HCA Holdings reported that in July, the Civil Division of the U.S. Attorney's office in Miami requested information on reviews assessing the medical necessity of interventional cardiology services at HCA facilities.

Nashville, Tenn.-based HCA included this information in its quarterly report to the Securities and Exchange Commission.

"Based upon the Company's review to date, which is not yet complete, the Company believes that such reviews have occurred at approximately 10 of its affiliated hospitals, located primarily in Florida. At this time, we cannot predict what effect, if any, the request or any resulting claims, including any potential claims under the federal False Claims Act, other statutes, regulations or laws, could have on the Company," the report said. ■

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Healthcare Reform After the Supreme Court: Where Do We Go Now

By Imran Andrabi, MD, Senior Vice President and Chief Physician Executive Officer, Mercy

This June, following much anticipation from those in the healthcare industry and consumers alike, the Supreme Court announced its decision to uphold nearly all of the Patient Protection and Affordable Care Act, including the individual mandate. The law impacts various sectors of the healthcare industry differently, but for hospitals, the Court's decision — even if it had decided to reject the mandate — wouldn't have changed the course on which many health systems are embarking. A reversal of the individual mandate would have meant less paying customers and continued increases in charity care, but most hospitals have long realized the current healthcare delivery system is unsustainable, and many, including Mercy, have started to make changes to welcome a new type of delivery system.

Within Mercy, we have been on this journey for some time to prepare for population health management and to redesign and retool how we provide care along the continuum for our patients and our community. We believe in this notion because, first, it is the right thing to do for the people we care for, and secondly, it is part of the fabric of our Mercy mission. It became clear to us that irrespective of what happened with the healthcare law, from a philosophical perspective, we were going to continue down our path of greater value for our patients, by emphasizing quality over volume, reducing costs in a systematic manner and improving access for our community.

How we'll do it

Managing the health of a population required a new mind set, new operational and clinical models and a new emphasis on things like coordination, care management, integration, communication, analytics and informed decision-making based on those clinical and business level insights. Even before that, we have been preparing the foundation by creating a broad network of physicians with the capability of taking care of our community with primary health and preventative medicine as well as in complex medical and surgical care. We are rapidly moving to certify all our primary care practices as Patient Centered Medical Homes, which we believe, will be the fundamental foundation of an integrated delivery model.

As we have prepared for this over the last several years, on the hospital side, we've implemented an entire transformation process to improve throughput, quality and coordination with the overall goal of becoming more efficient, effective and integrated in our clinical and logistics of healthcare delivery. As such, this has had a significant impact on our quality and safety outcomes as well as the experience our patients have when

they are being cared for at one of our hospitals. We have deployed several innovative methodologies and processes that have been significant accelerators in this journey.

Because of this innovative approach, technology needs to be utilized strategically as a connector of all the pieces of care. One of the ways Mercy has utilized technology is to enable a concept of one patient, one chart. By doing so, we are enabled to seamlessly follow the care of our patients across the continuum, give our physicians and other providers that data and the analytics to provide superior quality of care and enable our patients to engage with us in a meaningful way electronically to improve their health and wellbeing.

Additionally, one of our hospitals has applied for Medicare's Bundled Payments for Care Improvement program to begin testing bundled payments for cardiac care, through the Center for Medicare and Medicaid Innovation. This again is a key example of leading innovation and testing new models of care delivery that will become great tools as we move toward healthcare reform. All of these separate innovations will create the basis from which we will continuously learn and innovate new models of care today and in the future, allowing us to be ready to provide the highest quality, highest experience and highest reliability of care in the most personalized manner, thus fulfilling our mission to our community.

What's holding us back

While Mercy and many other organizations have begun to move in the right direction to improve healthcare quality and bend the cost curve, there are challenges ahead — and much more to be done. For one, with this magnitude of transformation, mindsets can be difficult to change. We've lived in a certain environment for a very long period of time and to move to a new one is not easy. Constant education, communication and articulating the value of change, is critical to shifting mindsets.

There is also the constant issue of living in two worlds, as the fee-for-service world and the pay-for-performance world currently coexist. Move too fast and actually reduce volume and improve health, and you don't get paid for it. Move too slow and you won't be ready once the shift happens. You have to captain two boats simultaneously; you don't want to over accelerate, but at the same time, you can't be too slow. As you're doing the right thing, you also have to make sure you're financially viable, so you can continue to deliver on your mission.



What's next

While the changes health systems are making to integrate and coordinate care and the Supreme Court's decision to uphold the PPACA are promising indicators that significant change in our healthcare delivery system can be achieved, we must continue to move in the right direction — toward the triple aim of higher quality, lower costs and improved health. Is there more that can be done? I think so.

Most of us in the industry know that doing nothing is not an option — it's not an option for people out there looking for care, and it's not a sustainable option for our delivery system. We've started the conversation and movement in the right direction, but we have to keep moving forward. For example, the PPACA did not address malpractice reform and what role that could potentially play in how physicians practice, how healthcare is delivered and the cost of care. Second, a great deal of our current efforts to reform is predicated on healthcare systems doing certain things; there are not a lot of incentives for patients' role in achieving healthy behaviors.

Even without the PPACA, and regardless of the political outcomes of the November election, these changes have to occur. Certain things are known: We have to provide higher quality care; we have to provide it at a lower cost; and we have to have access at the appropriate level of care. Whatever strategy hospitals select to pursue to achieve this — network development, ACOs, bundled payments, etc. — isn't as important as starting somewhere, starting anywhere. Whatever you do will be a building block to wherever you, and our delivery system, ultimately end up. ■

Imran Andrabi, MD, serves as senior vice president and chief physician executive officer for Toledo, Ohio-based Mercy, part of Catholic Health Partners. He previously served as president and CEO of Mery St. Vincent Medical Center in Toledo. He is a diplomat of the American Board of Family Medicine and the American Board of Managed Care Medicine.

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5 Responses to Healthcare Reform That Can Ensure Perioperative Success

By Sabrina Rodak

The majority of the news on the Supreme Court's upholding of the Patient Protection and Affordable Care Act has focused on the law's large-scale impact on patients and healthcare organizations in terms of health insurance and cost. What gets less attention but is equally important for healthcare leaders is health reform's effect on specific hospital service lines, such as surgery. Jeff Peters, president and CEO of Surgical Directions, shares the implications the Supreme Court's historic decision has for perioperative services and what five steps hospital leaders can take to ensure success.

Healthcare reform's impact on revenue and payment models

Mr. Peters says healthcare reform's two biggest effects on perioperative services are a reduction in reimbursement per patient or per procedure and an increase in the importance of clinical outcomes for payment. For states that opt in to PPACA's Medicaid expansion, more patients will be covered, but they will be covered at Medicaid's low reimbursement rates in comparison to commercial rates. For states that choose to opt-out, however, they will suffer from both reduced reimbursement and a constant rate of patients without insurance.

Lower reimbursement affects many hospital services, but its impact on surgical services may be particularly important for hospitals because operating room processes account for a large percentage of hospital revenue, according to Mr. Peters. As healthcare moves from a fee-for-service to a pay-for-performance model, perioperative services' reimbursement will also be determined in part by the value of patient care. "To respond, perioperative leadership needs to dramatically reduce the cost structure of perioperative services and put systems in place to ensure quality outcomes," Mr. Peters says. He suggests hospitals' surgical department accomplish these two goals by making the following five changes.

1. Establish a collaborative leadership structure. "The first thing [hospitals] need to do is change the way perioperative services are governed and put in a collaborative leadership structure where administration, OR nursing leadership, anesthesia and surgery are coming together to run the OR and to develop a plan that looks at reducing cost and improving clinical outcomes," Mr. Peters says. An example of a collaborative OR leadership structure is a surgical services executive committee that includes administration, physicians, anesthesiologists and nursing and is typically chaired by an anesthesiologist or surgeon. This committee functions as the board of directors of the OR, regularly looking at benchmarks to monitor performance and guide the strategic direction of the department, according to Mr. Peters.

2. Develop a perioperative services culture focused on quality, cost-efficiency. One of the most important responsibilities of OR leadership will be to create a perioperative services culture that focuses on quality, safety and cost efficiency. To accomplish this cultural change, leaders will need to examine the preoperative testing process and compliance with intraoperative best practices.

Beginning to manage patients' care at the time they schedule a surgery can help the OR improve quality by ensuring all comorbidities are accounted for and managed and reduce costs by preventing delays and cancellations. For example, Mr. Peters says if a patient schedules a joint replacement, the OR team should test the patient for anemia six weeks before surgery. If the patient does have anemia, the OR should arrange to have the problem addressed before the day of surgery to minimize the need for a blood infusion postoperatively. Similarly, if a diabetic patient schedules surgery, the OR team should ensure the patient's blood sugars are controlled early.

In addition to specific comorbidities, the preanesthesia testing team should evaluate the entire patient's profile to determine whether the patient may need to go into rehab or a nursing home after surgery and to start case planning before surgery.

Mr. Peters says anesthesiologists should play a central role in creating the policies and procedures in preoperative testing. "The role of the anesthesiologist has changed from putting the patient asleep and safely waking them up to managing the whole preoperative experience from a clinical level and a patient and surgeon satisfaction level," he says. "They need to own the OR and the whole preoperative process." Anesthesiologists are best equipped for this role because their incentives are aligned with those of the hospital, and they are in the OR the majority of the time, Mr. Peters says.

Best surgical practices

Following best practices during surgery can also help create a safe and efficient perioperative culture by improving outcomes and reducing costs through the prevention of infections and other complications. Mr. Peters suggests hospital ORs implement the World Health Organization surgical checklist, which forces the OR team to consciously note that all consents are signed, sites are marked and antibiotics have been given, among other practices. A time-out before the procedure to review the case and what site is being operated can also help avoid complications. In addition, before any clinician leaves the OR, the team should conduct a sign-out to verify the sponge and instrument count is correct to prevent retained objects, according to Mr. Peters.

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3. Gather and share quality and efficiency data. Making significant, sustainable improvements in cost and clinical outcomes requires the collection and monitoring of data. Mr. Peters suggests tracking the following measures:

- Surgical Care Improvement Project measures
- Hospital-acquired infection rates
- Deep vein thrombosis rates
- Pulmonary embolism rates
- Retained object rates
- Postoperative complication rates

This data should not be known only to a few leaders, but to all OR team members who can affect the measures. Mr. Peters suggests the OR provide surgeons with a dashboard that shows metrics such as their overall block utilization, case time by procedure, turnover time, cost per procedure, patient length of stay, patient complication rate and surgical site infection rate compared to the median rates. Monitoring this data can help surgeons and other clinicians identify opportunities for improvement and track trends.

4. Manage utilization. Carefully managing OR capacity and block time will be crucial to reducing costs and increasing revenue in the hospital. “It will be very difficult for hospitals to make money with block utilization below 85 percent,” Mr. Peters says. He suggests making blocks at least eight hours to help ORs fill the day’s schedule more efficiently. For example, he says if an OR has block times of four hours, the morning blocks would likely be popular, but blocks in the afternoon would be more difficult to fill, which would reduce utilization and increase costs.

Another way to optimize OR utilization is to allocate block times to only those surgeons who maintain at least 85 percent utilization of the block, according to Mr. Peters. However, it is important to examine not only a surgeon’s overall utilization, but also his or her time spent on each case. For example, if a surgeon maintains 85 percent utilization of a block but has excessive case time, that surgeon is not optimizing use of the block, Mr. Peters says. ORs should continually measure case time and other indicators of utilization to maintain high utilization over time.

Perioperative leaders should provide resources to surgeons to help boost their utilization levels. For example, leaders can assign a physician assistant

or an additional nurse to assist the surgeon and speed case time. In addition, surgeons who cannot maximize utilization of a long block can schedule cases in open rooms. Mr. Peters recommends leaving 20 percent of the OR’s capacity as open rooms for cases of surgeons without block time as well as for urgent and emergent cases. Open rooms provide flexibility for surgeons and can help optimize utilization.

5. Reduce non-labor costs. In most ORs, approximately 60 percent of costs are non-labor costs, and a significant portion of these are implants, according to Mr. Peters. There are several strategies perioperative leaders can take to reduce these costs. First, perioperative leaders can examine surgeons’ preference cards. By discussing differences in implants’ price and quality with surgeons, the OR may be able to standardize some of the products, which would reduce costs. Many

physicians are not aware of the cost of items or the differences in cost between vendors, according to Mr. Peters. Simply sharing this information can often spur physicians to reevaluate their preference cards and choose implants that are more cost effective but have the same quality outcomes, he says.

Perioperative leaders can provide incentives to physicians to standardize products or choose cost-efficient, quality implants. For example, leaders can establish a gain-sharing program in which a portion of the savings from standardizing implants is shared with the surgeons. The surgeons can then use these funds at their discretion, such as for purchasing additional equipment.

The OR can also cut costs by reducing the number of items in case packs and opting instead for packs that have only the essential instruments, according to Mr. Peters. Surgeons can then supplement the instruments with items outside the room. This practice can reduce waste because the OR would not have to throw out unused tools from a large pack that was opened.

Another option to reduce implant costs is to set price ceilings and accept products from only those vendors who bid prices below the ceiling, according to Mr. Peters.

Positioned for success

PPACA is revolutionizing the healthcare industry, and its effects will be seen at every level of a hospital, from the C-suite to the OR. By establishing a collaborative leadership structure and using data to drive improvements in efficiency and quality, perioperative services will be well-positioned to weather reimbursement cuts and to meet quality expectations. ■

Surgical Directions is the nation's premier surgical services consulting firm. We are led by nationally recognized anesthesiologists and surgical services professionals who passionately help our clients improve their perioperative services through operational and cultural transformation. The Surgical Directions team provides hands-on assistance in organizational design, strategic planning, scheduling optimization, materials and instrumentation management, information systems design, staffing, OR management, physician relations, anesthesia negotiations, and revenue cycle management. Over the past decade, we have successfully helped more than 130 hospitals increase surgical volume, improve surgeon and patient satisfaction, decrease costs, implement perioperative growth plans, and enhance overall perioperative and anesthesia performance.



300 Hospital and Health System Leaders to Know (continued from page 18)

Steven J. Corwin, MD. President and CEO of NewYork-Presbyterian Hospital (New York). Dr. Corwin assumed his current responsibilities in June 2011. Prior to his appointment as CEO, Dr. Corwin served as executive vice president and COO of the hospital, a position he held since 2005.

Toby Cosgrove, MD. CEO of Cleveland Clinic. Dr. Cosgrove joined the Cleveland Clinic in 1975 and became chairman of the Department of Thoracic and Cardiovascular surgery in 1989. He is also chair of Cleveland Clinic's board of governors in addition to his role as president and CEO.

J. Michael Cowling, CEO of Palm Beach Gardens (Fla.) Medical Center. Mr. Cowling previously served as a division vice president of Naples, Fla.-based Health Management Associates and CEO of Heart of Lancaster Regional Medical Center in Lititz, Pa., and Lancaster (Pa.) Regional Medical Center.

Gordon Crabtree, CFO of University of Utah Hospitals and Clinics (Salt Lake City). Mr. Crabtree has been University of Utah Hospitals since 2002. He previously worked with the Salt Lake Olympic Committee as the managing director of finance during the 2002 games.

Darcy Craven, CEO of Carolinas Hospital System (Florence, S.C.). Mr. Craven, who previously served as interim CEO and COO Carolinas Hospital System, was named CEO in July 2012.

Kathleen Crawford, COO of Ashtabula (Ohio) County Medical Center. Ms. Crawford has been COO of the hospital, which is an affiliate with Cleveland Clinic, since February 2010.

Susan Croushore, President and CEO of The Christ Hospital (Cincinnati). Before leading the 555-bed Christ Hospital, Ms. Croushore previously served as CEO of Jeanes Hospital-Temple University Health System in Philadelphia.

Kelly E. Curry, CFO of Health Management Associates (Naples, Fla.). Mr. Curry has served as executive vice president and CFO since January 2010. He was previously the company's chief administrative officer and COO.

Andrew Davis, President of Carney Hospital (Dorchester, Mass.). Mr. Davis previously served as CEO of Davis Regional Medical Center in Statesville, N.C., and as CEO of Sandhills Regional Medical Center in Hamlet, N.C.

Kenneth L. Davis, MD. President and CEO of The Mount Sinai Hospital (New York City). Prior to becoming CEO in 2003, Dr. Davis spent 15 years as chair of Mount Sinai's department of psychiatry and later served as dean

of Mount Sinai School of Medicine from 2003 to 2007 in addition to the CEO role.

Lloyd H. Dean, President and CEO of Catholic Healthcare West (San Francisco). Mr. Dean joined CHW in June 2000. He previously served as executive vice president and COO of Oak Brook, Ill.-based Advocate Health Care.

Ralph de la Torre, MD. Chairman and CEO of Steward Health Care System (Boston). Dr. de la Torre, a former cardiac surgeon, became president and CEO of Caritas Christi Health Care System in April 2008. The system was acquired by private equity firm Cerberus Capital Management and renamed Steward Health Care System in late 2010.

Kyle DeFur, President of St. Vincent Indianapolis Hospital. Mr. DeFur has served as president since December 2007. He also heads St. Vincent Women's Hospital, St. Vincent Stress Center and Peyton Manning Children's Hospital at St. Vincent.

Faye Deich, RN. COO of Sacred Heart Hospital (Eau Claire, Wis.). Ms. Deich previously served as CNO of Sacred Heart Hospital before assuming her current responsibilities as COO.

Robert A. DeMichie, Senior Vice President and CFO of University of Pittsburgh Medical Center. Mr. DeMichie has been senior vice president and CFO of UPMC since 2004. He previously held various financial leadership roles at General Electric and worked for PwC for 10 years.

Jackie DeSouza, CEO of Lee's Summit (Mo.) Medical Center. Ms. DeSouza was named CEO of Lee's Summit Medical Center November 2011 and previously served as COO of Kansas City, Mo.-based Research Medical Center.

Dick Dixon, CFO of Scott & White Healthcare (Temple, Texas). Mr. Dixon was named CFO in March 2012. He previously served as senior vice president of financial operations, and also serves as COO of Scott & White properties.

Michael J. Dowling, President and CEO of North Shore-Long Island Jewish Health System (Manhasset, N.Y.). Mr. Dowling became president and CEO of North Shore-LIJ in January 2002 and previously worked as the health system's executive vice president and COO.

Michael E. Duggan, CEO of Detroit Medical Center. Mr. Duggan was named CEO in January 2004, and under his tenure, the hospital made its first profit since 1997, transitioned to an electronic medical record and was named the main healthcare provider for major Detroit sports teams.

Victor J. Dzau, MD. President and CEO of Duke University Health System (Durham, N.C.). Dr. Dzau, a cardiologist, has been chancellor for health affairs at Duke University and

president and CEO of Duke University Health System since 2004.

Ann Errichetti, MD. CEO of St. Peter's Hospital (Albany, N.Y.). Dr. Errichetti was named CEO of St. Peter's Hospital in June 2012. She has served since 2009 as president of Advocate Condell Medical Center in Libertyville, Ill.

Duane L. Erwin, CEO of Aspirus (Wausau, Wis.). Mr. Erwin has served as president and CEO of Aspirus, which operates five hospitals and 35 community-based clinics, since 2006.

Cole C. Eslyn, President and CEO of Oklahoma University Medical Center (Oklahoma City). Mr. Eslyn has led Oklahoma University Medical Center since April 2007 and was previously CEO of St. David's Medical Center in Austin, Texas.

Melinda Estes, MD. CEO of Saint Luke's Health System (Kansas City, Mo.). Dr. Estes was named CEO of Saint Luke's Health System in June 2011 and previously served as president and CEO of Fletcher Allen Health Care in Burlington, Vt.

Daniel F. Evans, Jr., JD. President and CEO of Indiana University Health (Indianapolis). Mr. Evans was named to lead IU Health in November 2002. Before then, he was a partner with law firm Baker & Daniels.

Scott Evans, CEO of Keck Hospital of University of Southern California (Los Angeles). Mr. Evans was named to lead Keck Hospital and serve as CEO of USC Norris Cancer Hospital in July 2012. He had served as interim CEO since January 2012.

Brian Ewert, MD. President of Marshfield (Wis.) Clinic. Dr. Ewert, a nephrologist, was named president in January 2012. He previously served as the clinic's secretary from 2009 onward and was chairman of the nephrology department.

Sean M. Fadale, CEO of Community Memorial Hospital (Hamilton, N.Y.). Mr. Fadale assumed the CEO post in August 2012. He previously served as president of operations for Nicholas H. Noyes Memorial Hospital in Dansville, N.Y.

Pat Farrell, CEO of Henrico Doctors' Hospital (Richmond, Va.). In addition to his role as CEO, Mr. Farrell is the market lead for the Central Virginia market of Nashville, Tenn.-based Hospital Corporation of America's Capital Division.

David T. Feinberg, MD. President of UCLA Health System (Los Angeles). Dr. Feinberg has served as CEO and associate vice chancellor of UCLA Health since 2007. He previously served as medical director of UCLA's Resnick Neuropsychiatric Hospital and head of the NPH Faculty Practice Group.

Joseph G. Felkner, CFO of Health First (Rockledge, Fla.). Mr. Felkner was named CFO in April 2012. He previously served as CFO of the Lehigh Valley Health Network in Allentown, Pa.

Rick Ferguson, CEO of Oklahoma Surgical Hospital (Tulsa, Okla.). Mr. Ferguson leads this 76-bed, physician-owned hospital, which opened in July 2001 as the Orthopedic Hospital of Oklahoma and became Oklahoma Surgical Hospital in 2007.

Trevor Fetter, President and CEO of Tenet Healthcare (Dallas). Mr. Fetter joined Tenet in 1995 and served in various executive positions, including executive vice president and CFO, before becoming CEO in 2003.

Allan Fine, Senior Vice President of Strategy and Operations for New York Eye and Ear Infirmary (New York City). Mr. Fine assumed his position with New York Eye and Ear Infirmary, which is known as the country's first specialty hospital, in November 2007.

Peter S. Fine, President and CEO of Banner Health (Phoenix). Mr. Fine was named to lead Banner Health in November 2000. Prior to his appointment, he was executive vice president and COO for Milwaukee-based Aurora Health Care.

Jim Fiorenzo, President of UPMC Hamot (Erie, Pa.). Before Mr. Fiorenzo assumed leadership of UPMC Hamot, he served as the hospital's COO and senior vice president of strategic and support services.

Georgia Fojtasek, RN, President and CEO of Allegiance Health (Jackson, Mich.). Ms. Fojtasek joined Allegiance in 1989. She served as senior vice president and COO until 1994, when she was named CEO and president.

Teri G. Fontenot, President and CEO of Women's Hospital (Baton Rouge, La.). Ms. Fontenot leads the only freestanding, non-profit women's hospital in the United States. She is also the 2012 chair of the American Hospital Association Board of Trustees.

David Fox, President of Advocate Good Samaritan Hospital (Downers Grove, Ill.). Mr. Fox joined Advocate Good Samaritan in 2003. He previously served as president of Central DuPage Hospital in Winfield, Ill.

Joe Freudenberger, CEO of OakBend Medical Center (Richmond, Texas). Mr. Freudenberger has served as CEO since 2008. He served as the CFO and then acting CEO before becoming permanent CEO.

Patrick Fry, President and CEO of Sutter Health (Sacramento, Calif.). Mr. Fry joined Sutter Health in 1982 as an administrative resident at Sutter General Hospital, working his way up the ranks until he landed the position of president and CEO of the system.

Steven G. Gabbe, MD, CEO of Ohio State University Wexner Medical Center (Columbus). Dr. Gabbe joined OSU in July 2008 as senior vice president for health sciences and CEO of The Ohio State University Medical Center.

J.P. Gallagher, President of Evanston (Ill.) Hospital. Mr. Gallagher joined Evanston's parent, NorthShore University HealthSystem, in 2002 from the administrative team of Advocate Christ Medical Center in Oak Lawn, Ill.

Robert Garrett, President and CEO of Hackensack (N.J.) University Medical Center. Mr. Garrett has served as president and CEO of the 775-bed Hackensack University Medical Center since November 2009. Before then, Mr. Garrett served as the executive vice president and COO.

Stephen M. Gary, CFO of Akron (Ohio) General Health System. Mr. Gary began his role as CFO of Akron General Health System in January 2011. He previously served as senior vice president and CFO of St. Vincent Health System in Erie, Pa.

George Gaston, CEO of Memorial Hermann Southwest Hospital (Houston). Mr. Gaston assumed his position as CEO of Memorial Hermann Southwest Hospital in January 2010. Prior to his current position, Mr. Gaston served as CEO of Memorial Hermann Southeast Hospital for two years.

Steven C. Glass, CFO and Treasurer of Cleveland Clinic. Mr. Glass has been CFO of Cleveland Clinic since 2005. He is also CFO of Cleveland Clinic Health System.

Calvin Glidewell, CEO of Broward General Medical Center (Fort Lauderdale, Fla.). Mr. Glidewell was named CEO of Broward General and Chris Evert Children's Hospital in July 2011. He previously served as CEO of Imperial Point Medical Center in Fort Lauderdale.

Joseph Golbus, MD, President of NorthShore Medical Group (Evanston, Ill.). Dr. Golbus joined NorthShore University HealthSystem as a practicing physician in 1987 and has led the system's physician group since 1998.

Larry M. Goldberg, President and CEO of Loyola University Health System (Maywood, Ill.). Mr. Goldberg was named to lead Loyola University Health in September 2011. He previously served as CEO of Vanderbilt University Medical Center in Nashville, Tenn., for six years.

Richard Goldberg, MD, President of MedStar Georgetown University Hospital (Washington, D.C.). Dr. Goldberg has spent his entire medical career working for Georgetown, from his residency to his tenure as CMO.

Steven Goldstein, CEO of Strong Memorial Hospital and Highland Hospital (Rochester, N.Y.). Along with his role as president and CEO of Strong Memorial Hospital, Mr. Goldstein is vice president of University of Rochester Medical Center and president and CEO of Highland Hospital.

Arthur Gonzalez, CEO of Denver Health. Mr. Gonzalez was named CEO in July 2012. He previously served as CEO of Hennepin Healthcare System in Minneapolis.

Larry J. Goodman, MD, President and CEO of Rush University Medical Center (Chicago). Dr. Goodman, an internist, has been president and CEO of Rush University Medical Center since 2002. He oversees the "Rush Transformation," a \$1 billion rebuilding project expected to be completed by 2016.

Brett Gosney, CEO of Animas Surgical Hospital (Durango, Colo.). Mr. Gosney has a diverse background in healthcare, spanning more than 28 years. He is the immediate past president of Physician Hospitals of America, a Sioux Falls, S.D.-based trade group that represents physician-owned hospitals.

Gary Gottlieb, MD, President and CEO of Partners HealthCare (Boston). Dr. Gottlieb, a psychiatrist, has been president and CEO of Partners since January 2010.

Howard R. Grant, JD, MD, President and CEO of Lahey Clinic (Burlington, Mass.). Dr. Grant was previously executive vice president and CMO at Geisinger Health System in Danville, Pa.

Pauline Grant, CEO of Broward Health North (Deerfield Beach, Fla.). Ms. Grant has led the 409-bed Broward Health North since 2003. She previously served as vice president of ambulatory services for Fort Lauderdale, Fla.-based Broward Health.

Barbara Greene, President of Franciscan Physicians Hospital (Munster, Ind.). Ms. Greene has served in various healthcare executive roles, including Saint Margaret Mercy Healthcare Centers in Hammond, Ind., and Provena's St. Mary's Hospital in Kankakee, Ill.

Robert I. Grossman, MD, CEO of NYU Langone Medical Center (New York City). In addition to leading the medical center, Dr. Grossman is dean of the NYU School of Medicine. He joined NYU in 2001 as chairman of the department of radiology.

Dean Gruner, MD, President and CEO of ThedaCare (Appleton, Wis.). Dr. Gruner, a family physician, is president and CEO of ThedaCare and oversees ThedaCare's hospitals throughout central Wisconsin.

Joseph Guaraccino, Senior Vice President and CFO of The Brooklyn (N.Y.) Hospital Center. Mr. Guaraccino oversees the financial health of this 464-bed hospital.

Jesse P. Hall. President of NorthShore Highland Park (Ill.) Hospital. Mr. Hall joined the staff of NorthShore University HealthSystem in 2002 as senior vice president of Evanston (Ill.) Hospital. He previously held administrative positions with Geisinger Health System in Danville, Pa.

Michael Halter. CEO of Hahnemann University Hospital (Philadelphia). Mr. Halter has held his position at Hahnemann, a 478-bed academic medical center operated by Tenet Healthcare, since 1999.

George C. Halvorson. Chairman and CEO of Kaiser Permanente (Oakland, Calif.). Mr. Halvorson leads one of the largest non-profit health plan and hospital system in the United States, generating more than \$47 billion every year in revenue.

Richard Hammett. CEO of The Medical Center of Aurora (Colo.) and Centennial Medical Plaza. Mr. Hammett assumed his current title in August 2012. He previously served as COO of St. David's Medical Center in Austin, Texas.

Ken Hanover. President and CEO of Northeast Health System (Beverly, Mass.). Mr. Hanover serves as president and CEO of Northeast and executive vice president corporate development and chief strategy officer for Lahey Health System. Northeast affiliated with Lahey Clinic, a physician-led group practice, in May 2012 to form Lahey Health System, which acts as the governing body over Northeast Health and Lahey Clinic.

Misty Hansen. CFO of University of Arizona Health Network (Tucson). Ms. Hansen was Tucson, Ariz.-based UA Health Network's chief accounting officer before being named CFO in January 2010.

John P. Harney. President and CEO of University of Colorado Hospital (Aurora). Mr. Harney has served as president and CEO since March 2012 after having served as the hospital's COO since 2008.

Dean M. Harrison. President and CEO of Northwestern Memorial HealthCare (Chicago). Mr. Harrison has played an integral role in developing Northwestern Medicine, a joint strategic plan between Northwestern Memorial Hospital and the Northwestern University Feinberg School of Medicine. He joined Northwestern Memorial in 1998 as senior vice president of corporate operations.

Douglas D. Hawthorne. CEO of Texas Health Resources (Arlington). Mr. Hawthorne leads this network of 12 acute-care hospitals and other healthcare facilities.

Robert J. Henkel. President and CEO of Ascension Health (St. Louis). Prior to his appointment as president and CEO, Mr. Henkel served as executive vice president of Ascension Health Alliance, parent company of Ascension Health.

Cathryn Hibbs. CEO of Deaconess Hospital (Oklahoma City). Before serving as CEO of Deaconess Hospital, Ms. Hibbs held various positions within the for-profit hospital industry, including division vice president of operations for Franklin, Tenn.-based Community Health Systems.

Mairead Hickey, RN, PhD. COO of Brigham and Women's Hospital (Boston). Dr. Hickey became executive vice president and COO of Brigham and Women's in September 2010 and previously served as CNO and senior vice president of patient care services.

James Hinton. President and CEO of Presbyterian Healthcare (Albuquerque). Mr. Hinton has been with Presbyterian since 1983 and is the longest-tenured healthcare CEO in the state, having held the position since July 1995.

Rodney Hochman, MD. Group President of Providence Health & Services (Renton, Wash.). Dr. Hochman, a rheumatologist, serves as one of two group presidents for Providence's five-state system. He accepted the position in February 2012 after Providence and Seattle-based Swedish

Health Services announced an affiliation agreement. Dr. Hochman previously was president and CEO of Swedish for more than four years.

M. Michelle Hood. President and CEO of Eastern Maine Healthcare Systems (Brewer, Maine). Ms. Hood heads the seven-hospital Eastern Maine Healthcare Systems. Previously, she was CEO of St. Vincent Healthcare in Billings, Mont., and associate hospital director at Emory University Hospital in Atlanta.

Lars Houmann. President and CEO of Florida Hospital (Orlando). Mr. Houmann has been president and CEO of Florida Hospital, a 1,972-bed acute-care facility, since 1993.

Constance A. Howes, JD. President and CEO of Women & Infants Hospital of Rhode Island (Providence). Ms. Howes previously served as executive vice president and COO of Women & Infants and was formerly vice president and general counsel for Providence-based Care New England.

Michael D. Israel. President and CEO of Westchester Medical Center (Valhalla, N.Y.). Mr. Israel was named president and CEO of Westchester Medical Center in 2007. He has more than 30 years of healthcare experience and served as interim president and CEO for the hospital for two years before his permanent appointment.

Catherine Jacobson. President and CEO of Froedtert Health (Milwaukee). Ms. Jacobson assumed her leadership position as president and CEO in July 2012. She was named president of the system in 2011 after joining the system in 2010 as executive vice president of finance and strategy.

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Reynold J. Jennings. President and CEO of WellStar Health System (Atlanta). Mr. Jennings joined WellStar in August 2011 with more than 35 years of executive experience in hospital operations. He previously served as COO of Dallas-based Tenet Healthcare for four years.

Donald L. Jernigan. President and CEO of Adventist Health System (Altamonte Springs, Fla.). Mr. Jernigan oversees Adventist facilities in 10 states, along with 43,300 employees and more than 8,700 physicians. He was previously executive vice president of Adventist and CEO of Florida Hospital in Orlando.

Deborah Carey Johnson. President and CEO of Eastern Maine Medical Center (Bangor). Ms. Johnson worked her way up the ladder at EMMC, starting as a staff nurse in the critical care unit before assuming her current role as president and CEO.

R. Milton Johnson. President and CFO of Hospital Corporation of America (Nashville, Tenn.). Mr. Johnson served as executive vice president and CFO before assuming his current position in February 2011.

Laura Kaiser. COO of Intermountain Healthcare (Salt Lake City). Ms. Kaiser was named Intermountain's executive vice president and COO in January 2012. She previously served as president and CEO of Sacred Heart Health System in Pensacola, Fla., and Ministry Market Leader for the Gulf Coast/Florida region of Ascension Health.

Phillip M. Kambic. President and CEO of Riverside HealthCare (Kankakee, Ill.). Mr. Kambic assumed his leadership position in January 2006. He previously served as Riverside's senior vice president and COO.

Gary S. Kaplan, MD. Chairman and CEO of Virginia Mason Medical Center (Seattle). Dr. Kaplan has led Virginia Mason since 2000 and directed the system's Toyota Production System for healthcare management.

Chris Karam. President and CEO of CHRISTUS St. Michael Health System (Texarkana, Texas). As CEO of the Catholic, non-profit St. Michael Health, Mr. Karam oversees more than 2,000 employees.

Tom Karl. President of Parkland Health Center (Farmington, Mo.). Mr. Karl has been serving as president of Parkland Health Center, a hospital with two locations in Missouri's St. Francois County, since 2008.

Kenneth P. Kates. CEO of University of Iowa Hospitals and Clinics (Iowa City). Mr. Kates was named CEO of University of Iowa Hospitals and Clinics in July 2008. He previously held administrative positions at Temple University Hospital in Philadelphia as well as the University of Chicago Hospitals and Health System.

Donna Katen-Bahensky. President and CEO of University of Wisconsin Hospital and Clinics (Madison). Before beginning her current role in February 2008, Ms. Katen-Bahensky held numerous executive positions at health systems, including the University of Iowa Health Care in Iowa City.

William A. Keaton. CEO of Baylor Medical Center at Frisco (Texas). Mr. Keaton was appointed CEO of Baylor Medical Center at Frisco in 2001. He previously served as COO of River Region HealthCare System in Vicksburg, Miss., and CEO of Columbia Panhandle Surgical Hospital in Amarillo, Texas.

Robert A. Kent, DO. President and CEO of Summa Western Reserve Hospital (Cuyahoga Falls, Ohio). In three years, Dr. Kent transformed a struggling community hospital into a successful physician-led institution with a \$4.4 million profit in 2011.

Harris F. Koenig. President and CEO of San Antonio Community Hospital (Upland, Calif.). Mr. Koenig became CEO of San Antonio Community Hospital in June 2011. He previously served as CEO of Alvarado Hospital in San Diego for five years.

John Koster, MD. President and CEO of Providence Health & Services (Renton, Wash.). Dr. Koster has been president and CEO of Providence Health & Services since 2003 after joining the non-profit system in 1997.

Kelby K. Krabbenhoft. President and CEO of Sanford Health (Fargo, N.D., Sioux Falls, S.D.). Mr. Krabbenhoft joined Sanford Health in 1996 as president and became the health system's CEO in 1997. He has held executive positions in hospitals and health systems for more than 15 years.

Mark Krieger. Vice President and CFO of Barnes-Jewish Hospital (St. Louis). Before taking over as vice president and CFO of Barnes-Jewish Hospital in March 2004, Mr. Krieger had more than 20 years of experience in finance and strategic planning in the bakery business.

Mark Laney, MD. President and CEO of Heartland Health (St. Joseph, Mo.). Dr. Laney joined Heartland Health in 2009 after serving for 15 years as president of the Cook Children's Physician Network at Cook Children's Health Care System.

Menachem Langer, MD. CEO of Cookeville (Tenn.) Regional Medical Center. Dr. Langer became permanent CEO in April 2011 after having served as interim CEO.

Phyllis Lantos. CFO of NewYork-Presbyterian Hospital (New York City). Mrs. Lantos joined the hospital in 2000 as senior vice president and CFO and took on the executive vice president and CFO title in 2007.

Mark R. Laret. CEO of UCSF Medical Center (San Francisco). Mr. Laret has been CEO of UCSF Medical Center, including UCSF Children's Hospital, since April 2000. Mr. Laret spearheaded plans to build the \$1.5 billion UCSF hospital complex in the Mission Bay area of San Francisco, expected to open in 2014.

Robert J. Laskowski, MD. President and CEO of Christiana Care Health System (Wilmington, Del.). Dr. Laskowski, a geriatrician, became president and CEO of Christiana Care Health System in 2003. Before joining the system, he was CMO of Lehigh Valley Hospital and Health Network in Allentown, Pa.

Bruce Lawrence. President and CEO of Integris Health (Oklahoma City). Mr. Lawrence joined Integris in 2001. He served as president of Integris' Baptist and Southwest Medical Centers in Oklahoma City and executive vice president and COO of the system before becoming CEO.

Bill Leaver. President and CEO of Iowa Health System (Des Moines). Mr. Leaver has led Iowa Health System since 2008. He previously served as president and CEO of Trinity Regional Health System in Rock Island, Ill., for seven years.

Mary Jo Lewis. CEO of Sumner Regional Medical Center (Gallatin, Tenn.). Ms. Lewis has been CEO of Sumner Regional Medical Center since August 2010. Before then, she served as CEO of Jackson Purchase Medical Center in Mayfield, Ky., for 11 years.

Richard Liekweg. President of Barnes-Jewish Hospital (St. Louis). Mr. Liekweg assumed his post in September 2009. He previously served as CEO and associate vice chancellor for UCSD Medical Center in San Diego and spent more than 15 years at Durham, N.C.-based Duke University Health System.

Steven H. Lipstein. President and CEO of BJC HealthCare (St. Louis). Mr. Lipstein has served as president and CEO of BJC HealthCare, which includes Barnes-Jewish Hospital and 12 others, since 1999.

Steven N. Little. President and CEO of Agnesian HealthCare (Fond du Lac, Wis.). Mr. Little assumed his role as leader of Agnesian HealthCare in January 2012. He previously served as the organization's executive vice president.

Steven G. Littleson. President of Jersey Shore University Medical Center (Neptune, N.J.). In addition to his role as president of Jersey Shore University Medical Center, Mr. Littleson also serves as president of K. Hovnanian Children's Hospital in Neptune.

Kevin E. Lofton. President and CEO of Catholic Health Initiatives (Englewood, Colo.). Mr. Lofton has served as president and CEO of Catholic Health Initiatives since 2003.

Prior to joining CHI, Mr. Lofton served as CEO of the University of Alabama Hospital in Birmingham.

Susan Nordstrom Lopez, President of Advocate Illinois Masonic Medical Center (Chicago). Ms. Nordstrom Lopez began her role as president in October 2003. Prior to assuming her current position, she served as president and CEO of St. Anthony Medical Center in Crown Point, Ind.

Roberta Luskin-Hawk, MD, CEO of Saint Joseph Hospital (Chicago). Dr. Luskin-Hawk, an infectious disease specialist, became CEO of 321-bed Saint Joseph Hospital of Chicago, part of Resurrection Health Care, in 2009.

James Mandell, MD, CEO of Boston Children's Hospital. Dr. Mandell, a urologist, became CEO of Boston Children's Hospital in 2002.

Stephen L. Mansfield, PhD, President and CEO of Methodist Health System (Dallas). Dr. Mansfield has served as president and CEO of Methodist Health System since 2006. Before joining Methodist, Dr. Mansfield served seven years as president and CEO of the five-hospital St. Vincent Health System based in Little Rock, Ark.

Peter Markell, CFO and Treasurer of Partners HealthCare (Boston). In addition to his roles of CFO and treasurer, Mr. Markell also serves as Partners' executive vice president of administration and finance.

Barbara J. Martin, President and CEO of Vista Health System (Waukegan, Ill.). Ms. Martin has served as president and CEO of Vista Health System since 2006. The system includes 407 beds on two campuses.

Charles Martin, Jr. Chairman and CEO of Vanguard Health Systems (Nashville, Tenn.). Mr. Martin has been Vanguard Health System's chairman and CEO since the company's establishment in 1997. He founded Vanguard Health Systems with colleagues from his former employer, OrNda.

Patricia Maryland, DrPH, President and CEO of St. John Providence Health System (Warren, Mich.). Dr. Maryland has led St. John Providence Health System since January 2008. She previously served as executive vice president and COO of St. Vincent Health.

Stephen R. Mason, President and CEO of BayCare Health System (Clearwater, Fla.). Mr. Mason has served as president and CEO of BayCare since May 2004. He previously served as the senior executive vice president and COO of Texas Health Resources, headquartered in Arlington.

James E. May, CEO of Mercy Health (Cincinnati). Mercy Health includes six acute-care hospitals and a variety of other healthcare facilities. Mr. May also serves as divisional CEO and senior vice president for Cincinnati-based Catholic Health Partners.

John McCabe, MD, CEO of Upstate University Hospital (Syracuse, N.Y.). Dr. McCabe became CEO of Upstate University Hospital and senior vice president for hospital affairs in August 2009 after having served as interim CEO for two months.

Peter J. McCanna, Executive Vice President of Administration and CFO of Northwestern Memorial HealthCare (Chicago). Mr. McCanna is CFO and executive vice president for administration at Northwestern Memorial HealthCare as well as Northwestern Memorial Hospital in Chicago. He joined Northwestern Memorial in August 2002.

John D. McConnell, MD, CEO of Wake Forest Baptist Medical Center (Winston-Salem, N.C.). Dr. McConnell became the first CEO of Wake Forest Baptist Medical Center in 2008, coming from the University of Texas Southwestern where he served as executive vice president of health system affairs.

Tim McManus, CEO of Chippenham and Johnston-Willis Hospitals (Richmond, Va.). Mr. McManus started his tenure as CEO of Chippenham and Johnston-Willis Hospitals, which are part of HCA Virginia, in June 2012. He has CEO experience at several other HCA hospitals, including Reston (Va.) Hospital Center and Garden Park Medical Center in Gulfport, Miss.

David McQuaid, President and COO of Thomas Jefferson University Hospitals (Philadelphia). Mr. McQuaid has served as COO since 2007, and in July 2012, he took on the president title as well. He previously served as CEO for Duke University Health System's Durham (N.C.) Regional Hospital.

Chad Melton, CEO of HackensackUMC at Pascack Valley (Westwood, N.J.). In July 2012, Mr. Melton was named to lead the hospital, which is set to reopen in summer 2013 after closing in April 2008.

Carlos Migoya, President and CEO of Jackson Health System (Miami). Mr. Migoya began his tenure as chief of Jackson Health System in May 2011. He previously served as Miami's city manager and has more than 35 years of banking expertise.

Gary P. Miller, President and CEO of Saint Alexius Medical Center (Bismarck, N.D.). Mr. Miller was named to his current position in May 2011 after serving in the interim position. Prior to his interim role, Mr. Miller served as senior vice president and CFO.

Richard P. Miller, President and CEO of Virtua Health (Marlton, N.J.). Mr. Miller led the merger of two health systems that formed Virtua in 1998. Under his leadership, Virtua has formed clinical alliances with renowned organizations such as the Fox Chase Cancer Center and The Children's Hospital of Philadelphia.

Dan Moen, President and CEO of Legacy Hospital Partners (Plano, Texas). Mr. Moen co-founded LHP in January 2008. The company owns, operates and manages acute-care hospitals in small cities and in select urban markets.

Michael Moody, CFO of John Muir Health (Walnut Creek, Calif.). Mr. Moody has worked at John Muir Health for the past 19 years, and since December 2005, he has led all financial operations as CFO.

Cynthia Moore-Hardy, President and CEO of Lake Health (Painesville, Ohio). Ms. Moore-Hardy has led Lake Health as president and CEO since 1997. She has been with the system since 1988.

Joe Mullaney, President of Detroit Medical Center. Mr. Mullaney oversees DMC's strategic planning for healthcare reform and the develop-

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-Albert Einstein

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ment of its ambulatory care network. He came to DMC from Vanguard Health Systems' New England region, where he served as president.

Ralph W. Muller, CEO of University of Pennsylvania Health System (Philadelphia). Since 2003, Mr. Muller has led University of Pennsylvania Health System, which includes Pennsylvania Hospital, founded in 1751 by Benjamin Franklin.

Michael Murphy, President and CEO of Iowa Health System Accountable Care Organization (Des Moines). Mr. Murphy was named to lead IHS' ACO in April 2012. He previously led accountable care development and clinical integration programs at Trinity Health in Novi, Mich.

Kristen Murtos, President of Skokie (Ill.) Hospital. Ms. Murtos has been with NorthShore University HealthSystem since 1998, beginning her career there as vice president of the system's medical group.

Elizabeth G. Nabel, MD, President of Brigham and Women's Hospital (Boston). Dr. Nabel, a cardiologist, became president of Brigham and Women's and Faulkner Hospitals in January 2010. She was previously director of the National Institutes of Health's Heart, Lung, and Blood Institute

Harris M. Nagler, MD, President and CEO of Beth Israel Medical Center (New York). Dr. Nagler, a urologist, officially became president and CEO of Beth Israel Medical Center in March 2010 after serving as interim president for a year.

Mark R. Neaman, President and CEO of NorthShore University HealthSystem (Evanston, Ill.). Mr. Neaman joined NorthShore University HealthSystem as president and CEO in 1992. He has been with the health system since the beginning of his career, joining Evanston Hospital in 1974.

Edwin Ness, CEO of Munson Medical Center (Traverse City, Mich.). Mr. Ness became CEO of Munson Medical Center in 2004. He also serves as CEO of Munson Healthcare, a role he took on in 2010.

Robert E. Nesse, MD, CEO of Mayo Clinic Health System (Rochester, Minn.). Dr. Nesse was named CEO of Mayo Health System in March 2010. Since joining Mayo in 1980, Dr. Nesse served as residency program director for family practice and was vice chair of Mayo Clinic Department of Family Medicine.

Robert Nesselbush, President of Rochester (N.Y.) General Hospital. Mr. Nesselbush took the helm at Rochester General in June 2012. He previously served as CFO of Rochester General Health System.

Stephen L. Newman, MD, COO of Tenet Healthcare Corporation (Franklin, Tenn.). Dr. Newman, a pediatric gastroenterologist, became COO of Tenet Healthcare in 2007.

Gary D. Newsome, President and CEO of Health Management Associates (Naples, Fla.). Mr. Newsome was named president and CEO of HMA in September 2008. That same month, he became a member of the board of directors.

Mark Newton, President and CEO, Swedish Covenant Hospital (Chicago). Mr. Newton has led Swedish Covenant since 2000. Before then, he served as president of Highland Park (Ill.) Hospital.

John Noseworthy, MD, President and CEO of Mayo Clinic (Rochester, Minn.). Dr. Noseworthy became president and CEO in November 2009. He joined Mayo in 1990 and has served in various leadership positions, among them chairman of Mayo's Department of Neurology.

Ed O'Dea, CFO of Lehigh Valley Health Network (Allentown, Pa.). Mr. O'Dea was named CFO in May 2012 after holding the interim position for eight months. In 21 years of work at Lehigh Valley, Mr. O'Dea has also served as controller and vice president of finance.

Sharon O'Keefe, President of University of Chicago Medical Center. Ms. O'Keefe assumed her post as president in February 2011. Before then, she was president of Loyola University Medical Center in Maywood, Ill.

Stephen Ondra, MD, CMO of Northwestern Memorial Hospital (Chicago). Dr. Ondra, a neurosurgeon, was named to senior vice president and CMO in April 2012. He previously served as senior policy advisor for the U.S. Department of Veterans Affairs.

L. Reuven Pasternak, MD, CEO of Stony Brook (N.Y.) University Hospital. Dr. Pasternak was appointed CEO and vice president for health systems in September 2012. He previously served as CEO of Inova Fairfax Hospital and Campus in Falls Church, Va.

David Pate, MD, President and CEO of St. Luke's Health System (Boise, Idaho). Dr. Pate was named president and CEO in 2009. He previously served as CEO of St. Luke's Episcopal Hospital, an unrelated institution in Houston.

Ken Paulus, President and CEO of Allina Health (Minneapolis). Mr. Paulus became Allina Health's president and CEO in 2009. Before then, he served as the system's COO.

Ronald Paulus, MD, CEO of Mission Health System (Asheville, N.C.). Dr. Paulus became CEO in September 2010. Before then, he served five years at Geisinger Health System in Danville, Penn., as executive vice president of clinical operations and chief innovation officer.

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Susan Peach, CEO of HighPoint Health System (Gallatin, Tenn.). Ms. Peach became CEO in July 2012. She most recently served as CNO of the delta division of Brentwood, Tenn.-based LifePoint Hospitals' Hospital Support Center.

William M. Peacock, III, Chief of Operations for Cleveland Clinic. Mr. Peacock joined Cleveland Clinic in 2005 after serving 24 years with the U.S. Navy's Civil Engineer Corps, which oversees construction at naval bases around the world.

Megan Perry, President of Sentara Potomac Hospital (Woodbridge, Va.). Ms. Perry was named hospital president and vice president for Sentara's Northern Virginia market in July 2010. She began her career at Sentara in 1990 as an administrative resident.

Judith M Persichilli, RN, President and CEO of Catholic Health East (Newtown Square, Pa.). Ms. Persichilli has served as president and CEO since December 2009. She came to the system in 2003 as executive vice president of Catholic Health East's Mid-Atlantic Division.

Ora H. Pescovitz, MD, CEO of University of Michigan Health System (Ann Arbor). Appointed in 2009, Dr. Pescovitz is the first woman to serve as CEO of the University of Michigan Health System.

Ronald R. Peterson, President of The Johns Hopkins Health System and Johns Hopkins Hospital (Baltimore). Mr. Peterson has been president of The Johns Hopkins Hospital since 1996 and president of The Johns Hopkins Health System since 1997. He joined the system in 1973 as an administrative resident.

Bonnie Phipps, President and CEO of St. Agnes Healthcare (Baltimore). Ms. Phipps joined St. Agnes in 2006. Before then, she served as president and CEO of St. Joseph's Hospital in Atlanta.

Wright Pinson, MD, CEO of Vanderbilt Health System (Nashville, Tenn.). In addition to his role as CEO, Dr. Pinson is chief of staff at Vanderbilt University Hospital and chairman of the Vanderbilt University Medical Center Medical Board.

Karen Poole, Vice President and COO of the Boca Raton (Fla.) Regional Hospital. Ms. Poole, who was appointed COO in 2008, has more than 30 years of experience in healthcare.

John T. Porter, JD, President and CEO of Avera Health (Sioux Falls, S.D.). Mr. Porter has served as president and CEO since 1989. Before then, he served as executive vice president of the system for five years and as associate general counsel for 11 years.

Andrea Price, CEO of the Mercy Northern Region (Toledo, Ohio). Ms. Price has led Mercy since August 2010. Before then, she served as COO of the seven-hospital system.

Thomas Priselac, President and CEO of Cedars-Sinai Health System (Los Angeles). Mr. Priselac has been with Cedars-Sinai since 1979, serving as CEO since 1994.

Edward Prunchunas, Senior Vice President of Finance and CFO at Cedars-Sinai Medical Center (Los Angeles). Mr. Prunchunas has held his position since 1998. He previously served as CFO at Northridge (Calif.) Hospital Medical Center.

Mary Prybylo, President and CEO of St. Joseph Healthcare and St. Joseph Hospital (Bangor, Maine). Ms. Prybylo was named to the helm of St. Joseph in July 2012. She previously served as COO of Waterbury (Conn.) Hospital Health Center.

Robert W. Pryor, MD, President and CEO of Scott & White Healthcare (Temple, Texas). Dr. Pryor began his tenure as leader of Scott & White in April 2011. He previously served as CMO and COO.

Bill Pugh, Senior Vice President, Treasurer and CFO of PinnacleHealth (Harrisburg, Pa.). Mr. Pugh began his tenure as senior vice president, treasurer and CFO in December 2007. He has been a major part of hospitals and health systems across the country since 1978, when he was the director of finance of Banner Good Samaritan Hospital in Phoenix.

Joseph A. Quagliata, President and CEO of South Nassau Communities Hospital (Oceanside, N.Y.). Mr. Quagliata was named president and CEO of South Nassau Communities Hospital in 1998. He is stepping down at the end of 2012 and will be succeeded by Richard J. Murphy.

Paul Ramsey, MD, CEO of UW Medicine (Seattle). Dr. Ramsey, who serves as CEO of UW Medicine, also acts as executive vice president for medical affairs and dean of the School of Medicine at the University of Washington.

Michael Reney, CFO of Brigham and Women's Hospital and Faulkner Hospital (Boston). Mr. Reney joined Brigham and Women's in 1990 and has served as the hospital's CFO since May 2008.

James R. Renna, Executive Vice President and CFO of Steward Health Care System (Boston). Mr. Renna joined Steward from Cerberus Capital Management, where he served as a senior operations executive and business lead.

Stephen C. Reynolds, President and CEO of Baptist Memorial Health Care (Memphis). Mr. Reynolds began his career with Baptist Memorial Health Care in 1971 as an administrative resident. He assumed his post as president and CEO of the system in 1994.

Tim Rice, CEO of Cone Health (Greensboro, N.C.). Mr. Rice assumed his current title in April 2012, shifting the role of president to Terry Atkin. He originally served as president and CEO from 2004 onward, and as COO from 2001 to 2004.

Mimi Roberson, President and CEO of Presbyterian/St. Luke's Medical Center and Rocky Mountain Hospital for Children (Denver). Ms. Roberson assumed her post as CEO in 2000. Before coming to Denver, she was CEO of Women's and Children's Hospital and the Medical Center of Southwest Louisiana, both in Lafayette.

Jeffrey A. Romoff, President and CEO of UPMC (Pittsburgh). Mr. Romoff has served as UPMC's president since 1992 and as CEO since 2006. He began his career at University of Pittsburgh in 1973.

William L. Roper, MD, CEO of UNC Health Care System (Chapel Hill, N.C.). Dr. Roper is dean of the school of medicine, vice chancellor for medical affairs and CEO of the UNC Health Care System. He is also a professor of pediatrics and health policy and administration in the UNC School of Public Health.

David Ross, President and CEO of St. Joseph Hospital (Nashua, N.H.). Mr. Ross was named president and CEO of St. Joseph's Hospital in May 2010. He came to New Hampshire from Barnes-Jewish St. Peters (Miss.) Hospital, where he served as president.

Richard K. Rothberger, Corporate Executive Vice President and CFO for Scripps Health (San Diego). Mr. Rothberger, who has more than 30 years of experience in healthcare, has held his current position since August 2001.

Michael T. Rowan, Executive Vice President and COO of Catholic Health Initiatives (Denver). Mr. Rowan joined CHI in March 2004. Before then, he served as executive vice president and COO of St. John Health in Detroit.

Amir Dan Rubin, President and CEO of Stanford Hospital & Clinics (Palo Alto, Calif.). Mr. Rubin was named president and CEO of Stanford Hospital & Clinics in January 2011. He was previously COO of the 832-bed UCLA Health System in Los Angeles.

Dawn Rudolph, President and CEO of Saint Thomas Hospital (Nashville, Tenn.). Ms. Rudolph assumed her position as president and CEO of 541-bed Saint Thomas Hospital in November 2010. Before then, she served as CEO of St. Joseph Hospital in Fort Wayne, Ind.

Kathryn Ruscitto, President and CEO of St. Joseph's Hospital Health Center (Syracuse, N.Y.). Ms. Ruscitto began her tenure as president and CEO in January 2011. She has worked with St. Joseph's since 2001, serving as senior vice president for strategic development and governmental affairs.

Michael E. Russell, II, MD. President of Physician Hospitals of America (Washington, D.C.). Dr. Russell, a spine surgeon, is president of the board of directors for the national trade organization representing physician-owned hospitals.

Valinda Rutledge. President of Jewish Hospital, KentuckyOne Health Louisville Market Leader (Louisville, Ky.). Ms. Rutledge was named to her current post in July 2012. She came from CMS, where she served as the director of Patient Care Models Group for the Center for Innovation. Ms. Rutledge previously spent time as CEO of CaroMont Health in Gastonia, N.C., and Bon Secours Saint Francis Health System in Greenville, S.C.

Lee Sacks, MD. Executive Vice President, CMO of Advocate Health Care and CEO of Advocate Physician Partners (Oak Brook, Ill.). Dr. Sacks has served as CEO of Advocate Physician Partners since it was founded in 1995. He assumed his additional responsibilities as executive vice president and CMO in 1997.

Ernie Sadau. President and CEO of Christus Health (Irving, Texas). Mr. Sadau assumed the role of president and CEO of Christus Health in March 2011. He joined the system as senior vice president of patient and resident care operations in 2006, becoming senior vice president and COO in 2008.

Thomas J. Sadvary. President and CEO of Scottsdale (Ariz.) Healthcare. Mr. Sadvary joined Scottsdale Healthcare in 1986 as an administrator. He has served as CEO of the system since June 2005.

Steven M. Safyer, MD. President and CEO of Montefiore Medical Center (New York). Dr. Safyer was named president and CEO of Montefiore Medical Center in January 2008. Prior to his current appointment, he was the senior vice president and CMO of Montefiore for 10 years.

Todd Salnas. President of St. Joseph Health-Sonoma County (Santa Rosa, Calif.). Mr. Salnas was named president in July 2012. He previously served as executive vice president and COO of the system.

Anthony A. Scaduto, MD. President and CEO of Los Angeles Orthopaedic Hospital. Dr. Scaduto began his tenure as president and CEO in March 2012. He also serves as executive vice chair for the department of orthopaedic surgery at University of California Los Angeles in addition to other clinical leadership roles.

Judy Schanel. President of The Moses H. Cone Memorial Hospital (Greensboro, N.C.). Ms. Schanel was named president of the hospital and executive vice president of Moses Cone Health System in August 2010. Previously,

she was vice president and service line administrator for Cone Memorial Hospital.

Nancy Schlichting. President and CEO of Henry Ford Health System (Detroit). Ms. Schlichting has served as CEO of Henry Ford Health since 2003. She joined the system in 1998 as senior vice president and chief administrative officer, later becoming executive vice president and COO before her current post.

Kevin Schoeplein. CEO of OSF Healthcare (Peoria, Ill.). Mr. Schoeplein was named CEO of OSF Healthcare, which is associated with the The Sisters of the Third Order of St. Francis, in May 2011. His career with the Sisters has spanned 33 years.

Joseph A. Scopelliti, MD. President and CEO of Guthrie Health (Sayre, Pa.). Dr. Scopelliti, a practicing gastroenterologist, joined Guthrie Clinic in Sayre in 1984. He also serves as chairman of the Guthrie Graduate Medical Education Committee.

Michael Shabot, MD. CMO of Memorial Hermann Healthcare System (Houston). Dr. Shabot, who is board certified in general surgery and surgery critical care, is also an adjunct professor at The University of Texas Health Science Center in Houston. He previously served as the system's chief quality officer.

Steven Shapiro, MD. Senior Vice President and CMO of University of Pittsburgh Medical Center. Before joining UPMC in 2006, Dr. Shapiro served as chief of pulmonary and critical care medicine at Brigham and Women's Hospital and Harvard Medical School in Boston.

Terry D. Shaw. CFO and COO of Adventist Health System (Altamonte Springs, Fla.). With more than \$7.3 billion in revenues across hospitals in 10 states, Mr. Shaw oversees the finances of one of the largest faith-based health systems in the country.

John A. Shelton, Jr. President and CEO of DeKalb Medical Center (Decatur, Ga.). Mr. Shelton assumed his role as president and CEO in October 2011. He formerly served as the hospital's executive vice president and COO before a hiatus to serve at Mobile Infirmary, Alabama's largest non-profit hospital.

Mark Shields, MD. Vice President of Advocate Healthcare (Oakbrook, Ill.). Dr. Mark Shields is senior medical director for Advocate Physician Partners and vice president of medical management for Advocate Health Care. Mr. Shields oversees all clinical functions related to 4,000 physicians aligned with Advocate hospitals.

Douglas Silverstein. President of Glenbrook (Ill.) Hospital. Mr. Silverstein has been with NorthShore University HealthSystem since 1992.

Knox Singleton. CEO of Inova Health System (Falls Church, Va.). Mr. Singleton was named to lead Inova in 1984, when it was still called the Fairfax Hospital Association. Before joining Inova, he served as hospital director for the Hershey Medical Center of Pennsylvania State University in Hershey.

Sherrie Sitarik. President and CEO of Orlando (Fla.) Health. Ms. Sitarik was named to lead Orlando Health in February 2010. She previously served as executive vice president and chief strategy officer.

James H. Skogsbergh. President and CEO of Advocate Health Care (Oak Brook, Ill.). Mr. Skogsbergh has held several leadership positions throughout his career, including executive vice president of the Des Moines-based Iowa Health System and president and CEO of Iowa Methodist, Iowa Lutheran and Blank Children's hospitals.

Peter L. Slavin, MD. President of Massachusetts General Hospital (Boston). Dr. Slavin was named president of Massachusetts General in 2003. From 1999 to 2002, he served as chairman and CEO of Massachusetts General Physicians Organization.

Daniel Slipkovich. CEO of Capella Healthcare (Brentwood, Tenn.). Mr. Slipkovich, who has more than 30 years of hospital experience, co-founded Capella Healthcare in 2005.

Wayne Smith. President and CEO of Community Health Systems (Brentwood, Tenn.). Mr. Smith has led CHS since 1997. Before then, Mr. Smith spent 23 years with Humana.

John Smithhisler. President of St. Joseph Hospital and KentuckyOne Health Market Leader of Lexington (Ky.). Mr. Smithhisler took the helm as president of St. Joseph Hospital in July 2012. He came to KentuckyOne from Health Care Consulting in Shrewsbury, Mass., and previously served as president of Saint Vincent Hospital in Worcester, Mass.

Charles W. Sorenson, MD. President and CEO of Intermountain Healthcare (Salt Lake City). Before he assumed his current position as CEO in 2009, Dr. Sorenson served as Intermountain Healthcare's executive vice president and COO from 1998.

Phillip Sowa. CEO of Saint Louis University Hospital (St. Louis). Mr. Sowa became CEO in January 2011. He has served as CEO at other hospitals in the past, including Park Plaza Hospital in Houston and Tenet's Meadowcrest Hospital in Gretna, La.

Rulon Stacey, PhD. CEO of Poudre Valley Health System (Fort Collins, Colo.). Dr. Stacey came to Poudre Valley Health to assume the CEO post in 1996. Under his tenure, the system earned the Malcolm Baldrige National Quality Award.

Richard J. Statuto. President and CEO of Bon Secours Health System (Marriottsville, Md.). Mr. Statuto has led the non-profit, Catholic system since 2005. He first joined Bon Secours in 1987 as vice president of planning and marketing before leaving in 1990 to work for St. Joseph Health System in Orange, Calif.

Glenn Steele, Jr., MD. President and CEO of Geisinger Health System (Danville, Pa.). Dr. Steele has led Geisinger since 2001. Before then, he served as vice president for medical affairs, dean of Pritzker School of Medicine and professor in the department of surgery at University of Chicago.

Robert Steigmeyer. CEO of Community Medical Center (Scranton, Pa.). Mr. Steigmeyer was named CEO in July 2010. Prior to his current appointment, he served as senior vice president of operations and finance for the 300-bed Northwest Hospital & Medical Center in Seattle.

Shelbourn Stevens. President of Brunswick Novant Medical Center (Bolivia, N.C.). Mr. Stevens was named to lead Brunswick Novant in June 2012. He served as interim president since March 2012 and previously served as senior director of operations.

Thomas L. "Tim" Stover, MD. President and CEO of Akron (Ohio) General Health System. Dr. Stover became president and CEO of Akron General in February 2012. Previously, Dr. Stover was the president of Akron General's outpatient services and has been with the organization since 1993.

Alan Strauss. Executive Vice President and CFO of Carondelet Health Network (Tucson, Ariz.). Mr. Strauss officially joined Carondelet Health Network in April 2012. He spent the previous six years as CFO of Saint Thomas Health in Nashville, Tenn.

Douglas L. Strong. CEO of University of Michigan Hospitals and Health Centers (Ann Arbor). Mr. Strong joined University of Michigan Health System in 1998 and was named CEO of the system's hospitals and health centers in 2006.

David Strong. President of Rex Healthcare (Raleigh, N.C.). Mr. Strong was named to lead Rex Healthcare in 2004. Since then, Rex has earned Magnet nursing status from the American Nurses Association and also opened a state-of-the-art surgery center with digital operating rooms.

Paul Summerside, MD. CMO of BayCare Clinic and AuroraBayCare Medical Center (Green Bay, Wis.). Dr. Summerside, an emergency physician, has served as CMO and president of the board for BayCare Clinic and AuroraBayCare Medical Center since 1999.

Joseph R. Swedish. President and CEO of Trinity Health (Novi, Mich.). Mr. Swedish was named president and CEO of Trinity Health in December 2004. Prior to this appointment, he served at the helm of Centura Health in Englewood, Colo.

Ronald W. Swinford, MD. CEO of Lehigh Valley Health Network (Allentown, Pa.). Dr. Swinford has served as CEO of Lehigh Valley Health Network since November 2010. He previously served as CMO of the health network.

Michael C. Tarwater. CEO of Carolinas HealthCare System (Charlotte, N.C.). Mr. Tarwater has led Carolinas for 10 years. He first joined the system in 1981 after spending time as an assistant administrator with University of Alabama Hospitals in Birmingham.

Anthony Tersigni. President and CEO of Ascension Health Alliance (St. Louis). Mr. Tersigni was named president and CEO of Ascension Health Alliance in January 2012. Before this appointment, he served as president and CEO of Ascension Health since June 2004.

Warner Thomas. CEO of Ochsner Health System (New Orleans). Mr. Thomas was named CEO of Ochsner Health System in May 2012,

which will become effective in September. He previously served as president and COO of the health system.

William P. Thompson. President and CEO of SSM Health Care (St. Louis). Mr. Thompson became president and CEO of SSM Health Care in August 2011. Prior to this appointment, he served as president and COO.

Robert Thornton, Jr. President and CEO of SunLink Health Systems (Atlanta). Mr. Thornton has led SunLink Health Systems as CEO since 1998 and as president since 1996. Prior to that, Mr. Thornton was the company's CFO.

Peggy Troy, RN, MSN. CEO of Children's Hospital and Health System (Milwaukee). Ms. Troy has served as CEO of Children's Hospital and Health System since October 2008. She was previously COO of Methodist Le Bonheur Healthcare in Memphis, Tenn.

Nick Turkal, MD. President and CEO of Aurora Health Care (Milwaukee). Dr. Turkal has served as president and CEO of Aurora Health Care since 2007. He previously served as a senior vice president and president of Aurora's metro region, where he oversaw the operations of Aurora's facilities and services in the Milwaukee area.

Richard Umbdenstock. President and CEO of American Hospital Association (Washington, D.C.). Mr. Umbdenstock became president and CEO of AHA, which represents more than 5,000 member hospitals, in January 2007.

Kevin L. Unger. President and CEO of Poudre Valley Hospital (Fort Collins, Colo.). Mr. Unger has led Poudre Valley Hospital since 2005. He came to Poudre Valley Health System in 2001 and held the positions of vice president of planning and strategic development for the system and vice president of operations for the hospital.

Margaret Van Bree, CEO. St. Luke's Episcopal Hospital (Houston). Before Ms. Van Bree joined St. Luke's in 2009, she served as senior vice president and COO at the University of Wisconsin Hospital and Clinics in Madison.

Chris Van Gorder. President and CEO of Scripps Health (San Diego). Mr. Van Gorder has led Scripps Health, a five-hospital system, since 2000.

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David Vandewater, President and CEO of Ardent Health Services (Nashville, Tenn.). Mr. Vandewater has been with Ardent since 2001, when he started as chairman and later became president and CEO. Before Ardent, he served as president and COO of Nashville, Tenn.-based Hospital Corporation of America.

Anita S. Vaughn, RN, Administrator and CEO of Baptist Memorial Hospital for Women (Memphis, Tenn.). Ms. Vaughn has been with Baptist Memorial Health Care for more than 30 years and became the lead planner and developer of Baptist Memorial Hospital for Women in 1998.

Kevin Vermeer, Executive Vice President, CFO and Chief Strategy Officer of Iowa Health System (Des Moines). Mr. Vermeer was named executive vice president and CFO in 2009. He previously served as CFO for Trinity Regional Health System in Rock Island, Ill.

Paul S. Viviano, CEO of University of California San Diego Health System. Mr. Viviano officially started his tenure as CEO of UC San Diego Health System, as well as associate vice chancellor for health science, in June 2012. Other prior healthcare positions include president and CEO of USC University Hospital and USC/Norris Cancer Hospital.

Michael Vivoda, CEO of Cadence Health (Winfield, Ill.). Mr. Vivoda became president and CEO of Cadence Health July 2012. He previously served as president of Cadence Health's flagship hospital, Central DuPage Hospital in Winfield.

Alan Watson, CEO of Maury Regional Medical Center (Columbia, Tenn.). Mr. Watson has been the CEO of Maury Regional since June 2012, succeeding former CEO Robert Otwell, who retired. Mr. Watson was previously COO of the hospital.

Gary E. Weiss, CFO of NorthShore University HealthSystem (Evanston, Ill.). As executive vice president, CFO and treasurer of NorthShore University HealthSystem, Mr. Weiss also handles CFO duties for Evanston Hospital. Before coming to NorthShore in 2001, Mr. Weiss spent more than 25 years in banking and financial services.

Carl Whitmer, President and CEO of IASIS Healthcare (Franklin, Tenn.). Mr. Whitmer has nearly 20 years of experience in healthcare leadership. Before assuming the CEO role in 2010, he served as IASIS' CFO from 2001 onward.

Anthony D. Whittemore, MD, CMO at Brigham and Women's Hospital (Boston). Dr. Whittemore has served as CMO at Brigham and Wom-

en's Hospital since 1999. He joined the hospital's medical staff in 1976 and held various leadership roles before assuming his current position.

Robert Wiebe, MD, CMO for Dignity Health (San Francisco). Dr. Wiebe assumed his current position with Catholic Health West, now known as Dignity Health, in May 2008.

Guy R. Wiebking, President and CEO of Provena Health (Mokena, Ill.). When Provena formed in 1997, Mr. Wiebking became involved with the board of directors as a charter member. Throughout his tenure at Provena, he has served in various leadership capacities, including chair of the board from 2002 to 2006.

Stephen A. Williams, President and CEO of Norton Healthcare (Louisville, Ky.). Mr. Williams has been with Norton since 1977 and has served as president and CEO since 1993.

Nicholas Wolter, MD, CEO of Billings (Mont.) Clinic. Dr. Wolter leads Billings Clinic, which operates a 272-bed hospital, physician group practice, nursing home and research division.

Dan Wolterman, President and CEO of Memorial Hermann Healthcare System (Houston). Mr. Wolterman has led Memorial Hermann, the state's largest non-profit healthcare system, since 2002. He has more than 30 years of healthcare experience.

Terry Woodbeck, CEO of Tulsa (Okla.) Spine and Specialty Hospital. Mr. Woodbeck has more than 30 years of healthcare experience, with time spent in physician practice management, clinic administration and health finance research. He joined Tulsa Spine & Specialty Hospital after serving as CEO at Oklahoma Spine and Brain Institute, also in Tulsa, for four years.

Robert Wyllie, MD, Chief Medical Operations Officer of Cleveland Clinic. Dr. Wyllie was named CMO in April 2011. He previously served as institute chair for Cleveland Clinic Children's Hospital, on Cleveland Clinic's board of governors and on the board of trustees for the Clinic's Fairview and Lutheran hospitals, both in Cleveland.

Tom Zenty III, CEO of University Hospitals (Cleveland). Mr. Zenty has served as CEO since March 2003. Prior to assuming leadership of the system, Mr. Zenty was executive vice president for clinical care services and COO of Cedars-Sinai Health System in Los Angeles. ■

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10 Observations on the Affordable Care Act and Our Future

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

The Supreme Court has rescued the Patient Protection Affordable Care Act, at least for now. But is it worth saving? And regardless of what happens to the PPACA, what will be the future for U.S. healthcare?

These are really tough questions, so I solicited input from several friends of mine who are retired CEOs of hospital systems, including Kenneth Bloem, former president and CEO of Stanford University Hospital, Gary Mecklenburg, former CEO of Northwestern Memorial HealthCare, Doug Peters, former CEO of Jefferson Healthcare System, Dennis Barry, former CEO of Moses Cone Health System and Fred Brown, former CEO of Barnes-Jewish Hospital.

These distinguished healthcare leaders took their organizations through some big changes in the past, so who better to ask for guidance as we look into the future?

In lengthy interviews, they gave me many things to think about. Drawing on their input, I developed a list of ten observations on the impact of the PPACA on the future of healthcare. Not every leader I spoke with agreed with every point presented below, but I did my best to reflect upon their thoughts as I formulated my own conclusions.

1. The PPACA probably will just make things worse. The Affordable Care Act is a highly complex law and might be well intentioned, but it fails to address inherent problems in our healthcare system and could very easily do more harm than good.

The PPACA will continue to confuse everyone. It has not solved a thing, and has, in fact, exacerbated the problems we already have in healthcare: high costs, poor reimbursement, continued lack of access and more layers of regulation.

2. It's a tax-heavy law. The Supreme Court's decision considers the insurance mandate to be a tax, but it's not the only tax in the PPACA. Device-makers will pay a 1.3 percent tax on revenues, and hospitals will take a \$155 billion cut in payments over 10 years, which is a kind of a tax. In addition, non-profit hospitals will have to file extensive reports with the IRS to hold on to their tax-exempt status. And there will be a 40 percent tax on extra coverage provided by expensive Cadillac health insurance.

3. This law can easily get out of whack. The PPACA was supposed to function like clockwork, but it is actually a very unpredictable mechanism. It can easily get out of whack when something in it is altered. For example, if the Su-

preme Court had removed the mandate to buy insurance, guaranteed coverage for preexisting conditions would have been well nearly impossible.

Hospitals with a high Medicaid mix weren't so lucky. They were supposed to make up for the loss of \$155 billion in revenues by getting more patient volume from a state expansion of Medicaid, which was mandated under the law. But the Supreme Court shot down what was essentially a mandate. Hospitals in states that choose not to expand Medicaid will be left hanging out to dry.

4. Watch out for unintended consequences. Whoever put together this law (it would be interesting to know who these people were exactly) created incentives based on some theories about how people behave. These incentives have never been tested in reality, which means the law could lead to many unintended consequences.

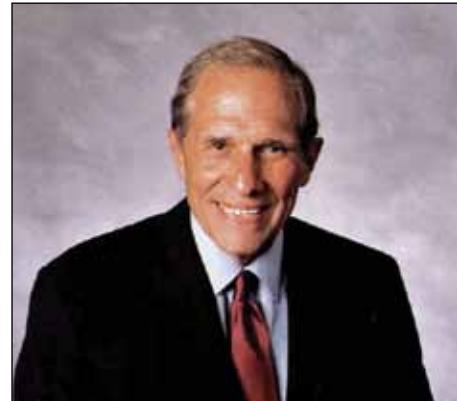
For example, what happens if there aren't enough physicians to serve the millions of Americans who will suddenly become insured? Rather than expanding access to care, the law could actually choke off access. And what happens if employers decide to drop worker coverage? The fine levied against them would be less than the premium they'd have to pay.

5. Prepare for a deluge of new regulations. Healthcare is already one of the most regulated sectors there is, and now it is about to get a whole lot more regulated. This could create another unintended consequence: A law that was supposed to reduce costs may actually drive up costs, due to the unbridled regulation.

So far, the PPACA has created 13,000 pages of new regulations, and many more pages still need to be written, according to Rep. Denny Rehberg (R-Mont.). All these rules will inevitably raise costs because hospitals and other players will need to hire more people to keep the books and to monitor compliance.

6. There's a 'one-size-fits-all' mentality. The mentality behind these new regulations seems to be that everyone needs to operate in the same way. One size fits all. The new Patient-Centered Outcomes Research Institute, for example, will develop wide-ranging standards of care that everyone will have to adopt. Eventually we will have a "paint-by-numbers" system of quality and efficiency that will make it very difficult for innovative CEOs to develop their own improvements, tailored to their own institutions and localities.

7. Will there be any savings to speak of? There are a lot of excesses in the health-



care system, but the PPACA doesn't really get at them and tends to throw money at problems. The HMOs of the 1990s were draconian and unpopular, but they produced savings. ACOs were conceived as a kinder, gentler version of HMOs, but it's hard to see how "shared savings" can really save a lot of money.

Meanwhile, a great deal of money is being spent to expand access under the PPACA. The federal government has set aside \$681 billion to subsidize people buying insurance through the health insurance exchanges over the next 10 years. The average person who buys a policy on the exchange may see his costs go down, but with the subsidies, the overall cost of buying the insurance could actually go up.

8. Healthcare has become a political football. Although the PPACA was almost entirely a Democratic concoction, Republicans don't come off smelling like roses. Both parties should have worked together to come up with the best reform plan possible. Instead, GOP politicians have sought to stir up fear in the American people with warnings about "death panels" and other issues that have nothing to do with sound policy-making. The mantra has become, "Whatever you are for, I'm against it." This is no way to create lasting policy for a sector of the economy as vital as healthcare.

If Barack Obama is reelected, he would then have the opportunity to correct deep flaws in the PPACA, such as the Independent Payment Advisory Board, which should be removed. If Mitt Romney is elected, he should bridge the partisan gap by assembling leaders in the healthcare field and asking them to come up with a new and improved reform plan. This non-partisan panel could adopt sensible reforms like a no-fault malpractice system and draw the line on price increases for drugs and medical devices. The goal should be to cut costs, establish patient-centered care and uphold quality.

9. Private sector reforms will continue. Whatever happens to the ACA, integration of the healthcare market will continue. Hospitals will not stop evolving into integrated systems, using systems like Geisinger, the Cleveland Clinic and Mayo as models. Commercial payors, backed by large employers, are offering incentives to integrated systems.

The key to integration, of course, is alignment with physicians, but doctors seem to be souring on their new role as hospital employees. Many of them are demanding more independent relationships. Recognizing the importance of physicians, we may see more hospitals systems appointing physician CEOs.

10. Next: Expect the unexpected. With costs out of control, leadership lacking and access in jeopardy, we appear to be on the verge of a major change in healthcare delivery. How it would change is not clear yet, but it

could be very surprising. For example, healthcare retail outlets staffed by nurses and boutique practices that don't deal with insurers could become pillars of the healthcare system, rather than interesting side issues.

The point is that the healthcare system is ready to become something completely different. And it could get a lot worse before it gets better, and evolve into something we didn't really want it to become. Healthcare could turn into a two-tiered system, with the richest 20 percent of Americans getting high-quality care while the rest of us struggle with increasingly mediocre care. That, I think, would be a tragedy. ■

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.

Hospital & Health System Transactions

Abington (Pa.) Health and Huntingdon Valley, Pa.-based **Holy Redeemer Health System** decided to end discussions regarding a potential partnership to create a larger health system.

St. Louis-based **Ascension Health Care Network** intends to acquire **St. Mary's Hospital** in Passaic, N.J.

The integration of **Bloomsburg (Pa.) Hospital** and its affiliates into Danville, Pa.-based **Geisinger Health System** received final approval from the Pennsylvania Attorney General's antitrust division.

Winfield, Ill.-based **Cadence Health** and Oak Brook, Ill.-based **Advocate Healthcare** are finalists to merge with **Sherman Health** in Elgin, Ill.

Franklin, Tenn.-based **Capella Healthcare** finalized its long-term lease and management agreement to acquire **Muskogee (Okla.) Community Hospital**, creating one comprehensive health system comprised of Muskogee Community Hospital and **Muskogee (Okla.) Regional Medical Center**.

Englewood, Colo.-based **Catholic Health Initiatives** and Omaha, Neb.-based **Immanuel Communities**, the co-sponsors of **Alegent Health** in Omaha, have signed a letter of intent for CHI to become the sole sponsor of Alegent Health.

The sale of Jersey City, N.J.-based **Christ Hospital** to **Hudson Holdco**, a real estate development company in Pennsylvania, finalized, officially ending a lengthy sale process.

Franklin, Tenn.-based **Community Health Systems** announced that its subsidiaries acquired most of the assets of York, Pa.-based **Memorial Health Systems**.

The city council approved **Cookeville (Tenn.) Regional Medical Center's** request to purchase **Cumberland River Hospital** in Celina, Tenn., from **Restoration Healthcare** of Celina for \$6.75 million.

Hackensack (N.J.) University Health Network and **LHP Hospital Group** in Plano, Texas, completed a joint venture purchase of **Mountainside Hospital** in Montclair, N.J., from Louisville, Ky.-based **Merit Health Systems**.

Brentwood, Tenn.-based **LifePoint Hospitals** acquired **Woods Memorial Hospital** in Etowah, Tenn.

Los Robles Hospital & Medical Center in Thousand Oaks, Calif., and **Thousand Oaks Surgical Hospital** have agreed in principle to a deal and are sharing information in a due diligence process.

Marquette (Mich.) General Health System announced that it has signed a definitive agreement for **Marquette General Hospital** to be acquired by **Duke LifePoint Healthcare** in Brentwood, Tenn.

Rochester, Minn.-based **Mayo Clinic, Fairview Health Services** in Minneapolis and **Fairview Red Wing (Minn.) Health Services** signed a tentative agreement for Fairview Red Wing Health Services to become part of Mayo Clinic Health System.

Bismarck, N.D.-based **Medcenter One** and **Sanford Health** based in Fargo, N.D., and Sioux Falls, S.D., completed the final steps to move forward with their merger.

Mountain View Hospital in Madras, Ore., is planning to negotiate an asset transfer agreement with Bend, Ore.-based **St. Charles Health System**.

The boards of **NYU Langone Medical Center** and **Continuum Health Partners**, both New York City-based non-profits, approved a memorandum of understanding for a merger that would create one of the largest healthcare systems in New York City. However, merger discussions between the two broke down abruptly after Continuum received a competing offer from another New York City-based hospital system, **Mount Sinai Medical Center**.

Washington, Mo.-based **Patients First Health Care** and Chesterfield, Mo.-based **Mercy** completed a merger to integrate Patients First into Mercy.

Ontario, Calif.-based **Prime Healthcare** completed its purchase of **Saint Mary's Regional Medical Center** in Reno, Nev., from **Dignity Health** in San Francisco, formerly Catholic Healthcare West.

A federal bankruptcy judge denied Ontario, Calif.-based **Prime Healthcare's** request to acquire **Victor Valley Community Hospital** in Victorville,

Calif., in favor of approving Riverside, Calif.-based **KPC Group** as the buyer.

Toledo, Ohio-based **ProMedica** signed an agreement with **Memorial Hospital** in Fremont, Ohio, to establish a long-term relationship with the intent of Memorial Hospital becoming a member of ProMedica.

Salinas (Calif.) Valley Memorial Healthcare System's steering group submitted a recommendation advising the SVMHS board to end the affiliation process with **Natividad Medical Center** in Salinas.

St. Louis-based **SSM Health Care** finalized its acquisition of **Unity Health Center** in Shawnee, Okla.

Akron, Ohio-based **Summa Health System** announced plans to explore a strategic partnership with another non-profit healthcare organization.

Atlanta-based **SunLink Health Systems** completed the sale of its **Memorial Hospital of Adel (Ga.)** and **Memorial Convalescent Center in Adel** to **The Hospital Authority of Tift County (Ga.)** for approximately \$8.35 million.

University of Colorado Health, a new organization that includes Loveland, Colo.-based Medical Center of the Rockies; Poudre Valley Hospital in Fort Collins, Colo.; and University of Colorado Hospital in Aurora, Colo., intends to begin negotiating a management agreement with **Ivinson Memorial Hospital** in Laramie, Wyo.

Valley General Hospital in Monroe, Wash., restarted its merger discussions and is considering **Providence Regional Medical Center Everett (Wash.)** and **Evergreen Healthcare of Kirkland (Wash.)** as potential partners.

Verdugo Hills Hospital in Glendale, Calif., entered into merger talks with the **University of Southern California's Keck Medical Center** in Los Angeles.

Wyoming County Community Health System in Warsaw, N.Y., is looking to affiliate with the **University of Rochester (N.Y.) Medical Center**.

Hospital & Health System Executive Moves

Steven P. Boyle, CEO of Albany, N.Y.-based St. Peter's Health Partners, will retire Oct. 1 after 24 years of executive leadership within the system.

Rockledge, Fla.-based Wuesthoff Health System named **Tim Cerullo** as CEO of Wuesthoff Medical Center-Rockledge.

Carolinas Hospital System in Florence, S.C., named **Darcy Craven** as CEO.

The Denver Health and Hospital Authority board has named Arthur Gonzalez to succeed **Patricia Gabow**, PhD, as CEO of Denver Health.

Mayo Regional Hospital in Dover-Foxcroft, Maine, named **Edward Hannan** CEO.

Bartlett Regional Hospital in Juneau, Alaska, has named **Christine Harff** as CEO.

St. Luke's Sugar Land (Texas) Hospital named **Robert Heifner** CEO effective July 9.

Jeffrey Hillebrand, COO of Evanston, Ill.-based NorthShore University HealthSystem, retired from his position to launch a healthcare consulting firm.

Catherine Jacobson assumed the role of president and CEO of Milwaukee-based Froedtert Health.

Newton-Wellesley Hospital in Newton, Mass., announced that **Michael Jellinek**, MD, will step down as president.

Northern Berkshire Healthcare in North Adams, Mass., named **Timothy Jones** as president and CEO.

Ontario, Calif.-based Prime Healthcare named **Helen Lidholm**, MBA, as CEO of Saint Mary's Regional Medical Center in Reno, Nev.

OhioHealth in Columbus announced that **Greg Long** will be the president and CEO of O'Bleness Health System in Athens, Ohio.

Plano, Texas-based LHP Hospital Group and Hackensack (N.J.) University Medical Center named **Chad Melton** as CEO of HackensackUMC at Pas- cack Valley in Westwood, N.J.

Mineral Area Regional Medical Center in Farmington, Mo., and Franklin, Tenn.-based Capella Healthcare — of which MARMC is a part — named **Lynn Mergen** as CEO.

Jim Meyer, CEO of MedCentral Health System in Mansfield, Ohio, and its predecessor Mansfield (Ohio) General Hospital, retired.

After seven months as president and CEO of Bozeman (Mont.) Deaconess Hospital, **Stan Moser** resigned.

New York City-based Richmond University Medical Center CEO **Richard Murphy** stepped down to serve as president and CEO of South Nassau Communities Hospital in Oceanside, N.Y.

Ontario, Calif.-based Prime Healthcare named **Bockhi Park** as CEO of Sherman Oaks Hospital and Encino Hospital Medical Center in Los Angeles.

HighPoint Health System in Gallatin, Tenn., named **Susan Peach**, BSN, MBA, as CEO.

Newman Regional Health in Emporia, Kan., named **John Rossfeld** named as interim CEO.

Valinda Rutledge was named president of Jewish Hospital in Louisville, Ky., and leader of parent company KentuckyOne Health's Louisville market.

Amarillo, Texas-based Northwest Texas Healthcare System CEO **Kyle Sanders** announced his resignation.

The Tulare (Calif.) Local Healthcare District board of directors named **Kevin Shimamoto** as interim CEO of Tulare Regional Medical Center.

Tommy Smith, president and CEO of Louisville, Ky.-based Baptist Healthcare System, intends to retire next April.

Thompson Health in Canandaigua, N.Y., named **Michael Stapleton** president and CEO.

Coastal Carolina Hospital in Jasper, S.C., which is owned by Dallas-based Tenet Healthcare, named **Brad S. Talbert** as CEO.

Community Hospital Anderson (Ind.) named **Beth Tharp** as president and CEO.

Gulf Coast Medical Center in Panama City, Fla., named **Carlton Ulmer** as CEO.

Western Arizona Regional Medical Center in Bullhead City, Ariz., named **Alex Villa** as CEO.

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