

The Hospital Review

BUSINESS & LEGAL ISSUES FOR HOSPITAL LEADERSHIP

10 Ways to Improve Your Hospital's Orthopedic Program

By Mark Taylor

As acute care hospitals face growing competition, protecting their orthopedic surgery departments becomes increasingly valuable. Not-for-profit acute care hospitals depend on that revenue to subsidize money-losing services and attract new patients. Reimbursements from public and private insurers for orthopedic surgery remain high.

"If an orthopedics program is not profitable, there are underlying problems with operations, cost containment or other financials," says Harry Herkowitz, MD, chairman of orthopedic surgery for William Beaumont Hospitals in Royal Oaks, Mich. "It's unusual for an orthopedics department not to be profitable. It should be one of the most profitable service lines."



Harry Herkowitz, MD
Chairman of Orthopedic
Surgery, William
Beaumont Hospitals

The Hospital Review queried nine respected hospital

orthopedics professionals whose hospitals have garnered national and international fame for the quality and success of their orthopedics programs. Here's their advice for improving the quality, patient satisfaction and profitability of hospital orthopedic programs.

1. Involve physicians.

"Don't just pay lip service. Real, meaningful physician engagement is vital and should focus around staffing, clinical patient, financial, operational and other issues," advised Anna Silva, vice president for ancillary services with 530-bed Our Lady of the Lake Regional Medical Center in Baton Rouge, La. Their program controls a 45 percent market share and ranks above the 90th percentile in patient satisfaction. "Our philosophy has been to try to build the best program in the state and invite them to build it with us. We make suggestions, but ultimately the physicians assume the lead."

Kellie Risser of Risser Consulting of Columbus, Ohio, and former CFO for the New Albany Surgical Hospital in New Albany, Ohio, says physician involvement makes a much richer hospital orthopedics program and offers a stronger patient continuum of care, from the physician office through the hospital stay and into physical therapy and rehabilitation.

"The more involved the physicians are in the whole care and management of the program, the more successful it will be," Ms. Risser says. "It also sends a consistent message to patients. When doctors are engaged they become aware of hospital costs and can help hospitals reduce unnecessary costs."

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24 Hospital Leaders to Know

By Scott Becker and Rob Kurtz

1. Jack Bovender Jr. — Jack Bovender Jr. is the chairman and CEO of Hospital Corporation of America (HCA). He assumed this role in January 2002. Prior to this position, Jack served as HCA's executive vice president and COO for about ten years, and was division president of HCA's Atlanta division and president of HCA's Eastern Group Operations. Prior to joining HCA, Jack served as a lieutenant in the United States Navy, and as CEO of Medical Center Hospital in Largo, Fla., and West Florida Regional Medical Center in Pensacola, both owned at the time by HCA.

2. Irene Cumming — Irene Cumming has served as the president and CEO of University HealthSystem Consortium (UHC) in Oak Brook, Ill., an alliance of 101 academic medical centers and 178 of their affiliated hospitals representing approximately 90 percent of the nation's non-profit academic medical centers, for more than 12 years. She

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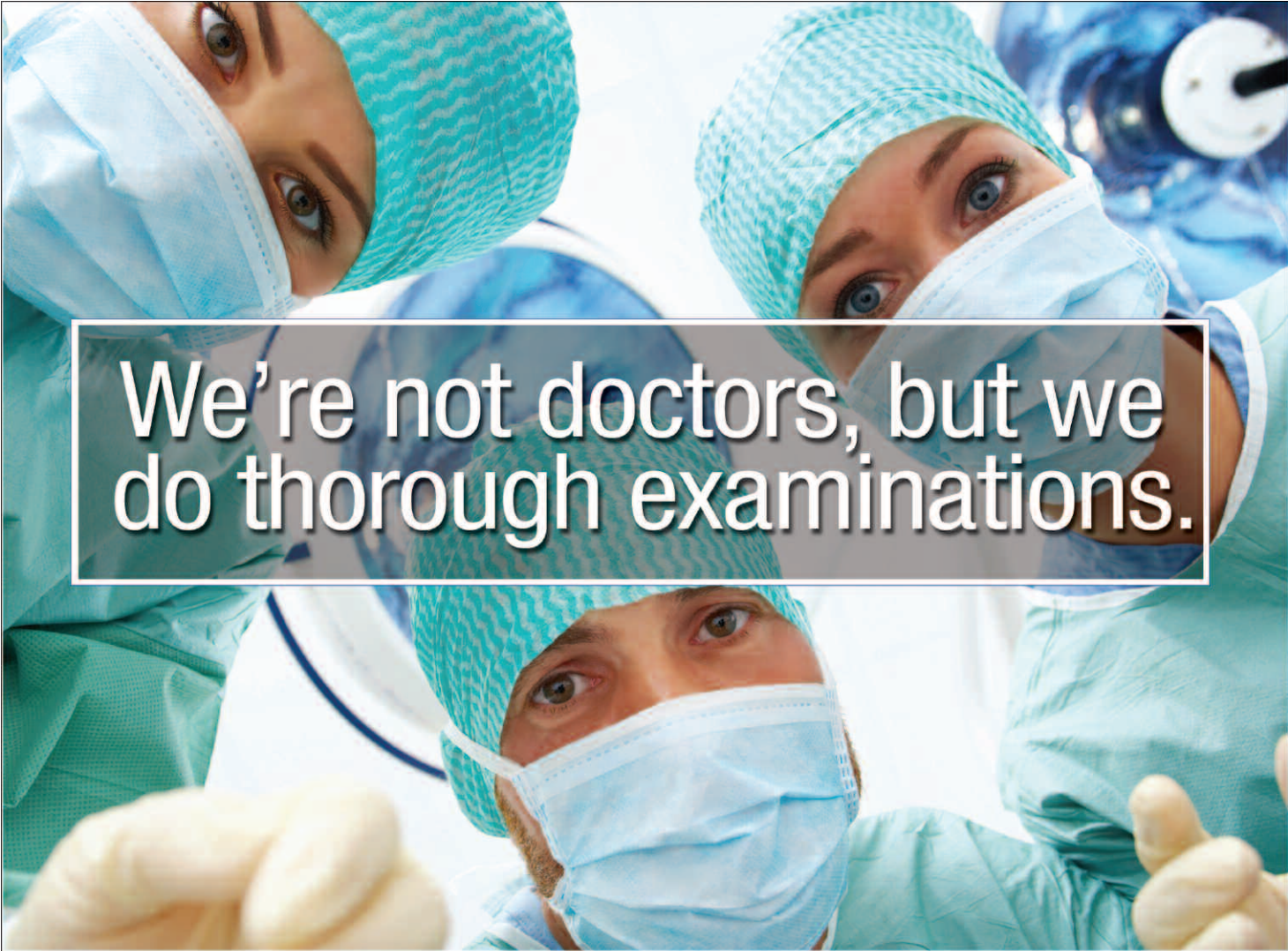
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Letter from the Editor

Five Evolving Trends for Health Systems; Uwe Reinhardt to Keynote 15th Annual Ambulatory Surgery Center Conference

There are several interesting trends evolving in the healthcare and hospital system area. These include the following issues:

1. Evolving towards employee models. We are seeing a substantial increase in systems establishing part time and full time employment models with physicians. This is focused as much towards specialists as it is towards internists and primary care physicians.

2. Growing divide between the haves and have nots. In the hospital area, it is becoming clear that 20 percent to 25 percent of the nation's hospitals are thriving tremendously. At the same time, there is a great balance of hospitals that are struggling significantly. It continues to be a great split and divide amongst hospitals.

3. Joint ventures can help, but not a panacea. Over the last five years, the strategy of joint venturing with physicians has remained a solid method for developing alliances with physicians. At the same time, many hospitals are finding that it is not a strategy that fits all problems and all issues. This, in part, explains the movement towards employment models. In essence, systems find that they can use joint ventures to solve a part of their physician and capital problems but find that it is also necessary to engage and focus efforts around employment and other models.

4. Exponential increase in electronic health records and information systems integration. Over the past 12 to 18 months, we have witnessed tremendous growth in the implementation of models between physicians and hospitals relating to integration of medical records. We expect this to continue for the next 24 to 36 months. Our next issue will include a significant article on nine things you should know about the Stark Act rules related to electronic health records donations to physician practices.

5. Recovery audit contractors are here to stay. Recovery audit contractors continue to demonstrate significant results in returning funds to the Medicare/Medicaid programs. Notwithstanding their lack of popularity, we expect this to continue as a strategy to help recover costs in the health-care sector.

The last quarter of the year should be a very exciting one. The election results, together with continued pressure on healthcare costs, should make the next several months and next year an interesting one in the healthcare sector.

For more information and updates on the hospital sector, please visit www.hospitalreviewmagazine.com.

Uwe Reinhardt to Keynote 15th Annual ASC Conference.

For those interested in ambulatory surgery centers, we have the 15th Annual Ambulatory Surgery Center Conference scheduled for October 23rd to 25th at the Sheraton Hotel and Towers in Chicago. There, we will have Uwe Reinhardt giving the keynote address. We also have a great list of topics and issues up for discussion.

Here are some of the sample topics that are being discussed at that meeting. Overall, there will be more than 75 presentations. We expect an outstanding turnout.

- Successful Structuring of Physician-Hospital ASC Joint Ventures — *Joe Zasa, CEO, Woodrum ASD; Deanne Manchester, USPI; Amber Walsh, and Elissa Moore, McGuireWoods*
- Orthopedics in ASCs: What Can You Expect in the Next Five Years — *John Cherf, MD, Dept. of Orthopedics, The Neurological & Orthopedic Hospital of Chicago*
- The State of the Union for ASCs — *Kathy Bryant, President, ASC Association*
- Can Two Centers Thrive by Merging? — *Tom Yerden, CEO and Founder, TRY Health Care Solutions*
- Gastroenterology, ENT, Ophthalmology, Pain Management and Bariatrics in ASC: What Works and What Doesn't — *Anne Roberts,*

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Surgery Center of Reno; Steve Blom, San Antonio Surgery Center; John Poisson, Executive VP, Physicians Endoscopy; Dr. Douglas Hoisington

- Practical Case-Costing and Benchmarking for ASCs — *Alsie Sydness-Fitzgerald*
- The Future of ASCs — *Dr. Mark Koch, Somnia, Inc.; Tom Mallon, CEO and Founder, Regent Surgical Health; Tony Taparo, Symbion, Inc.*
- Assessing the Profitability of Different Specialties in ASCs — *Luke Lambert, CEO, ASCOA*
- From ASC to Hospital: What are the Pros and Cons of a Conversion to a Hospital? — *Brett Gosney, CEO, Animas Surgical Hospital*
- Will the Stark Laws Close Down ASCs? — *Amber Walsh and Melissa Szabad, McGuireWoods*
- Safe Harbor, OIG Work Plan and Out-of-Network Issues — *Scott Becker and Scott Downing, McGuireWoods*

Should you have any questions related to any of these issues, please contact me at (312) 750-6016 or at sbecker@mcguirewoods.com; or contact *The Hospital Review*, Becker Healthcare Communications, at (800) 417-2035.

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Scott Becker

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10 Ways to Improve Your Hospital's Orthopedic Program (continued from pg. 1)

Engaging physicians also requires involving them in quality initiatives. "Once doctors see comparative utilization and peer-to-peer data, they respond," observes Steve Thomas of the Indianapolis-based consulting firm Health Evolutions. "There's almost always an opportunity for improvement when both sides are interested, committed and truly engaged."

Victor DiPilla, vice president of operations for The Christ Hospital in Cincinnati, says his hospital needed to rebuild its orthopedics program several years ago after losing a large orthopedics group over disputes on standardization of implants and other devices and on-call coverage. By engaging the physicians who remained, The Christ Hospital was able to reduce its patient length of stay, cut costs and improve patient satisfaction through several physician-initiated programs and purchases.

And that has grown the program as well. By implementing pre-operative screening procedures, it has seen a 60 percent reduction in surgical site infections, and by launching a pain block program, The Christ Hospital has decreased patient nausea, allowing patients to complete their physical therapy and rehabilitation on schedule. It has also improved patient satisfaction and allowed next-day discharges for many joint procedures, he says.

2. Create a dedicated orthopedics wing or building.

"The physician-owned hospital debate has infused a degree of competition into the marketplace," says John Martin, CEO of Indiana's largest orthopedics practice, 70-physician OrthoIndy. Mr. Martin also oversees the 37-bed Indiana Orthopaedic Hospital, ranked that state's top orthopedics hospital.

"There are some real advantages to segmenting services, advantages in improving patient care and growing the bottom line," Mr. Martin says. "When orthopedic patients come into a hospital and go to an area focused on orthopedic care, whether it's a for-profit, physician-owned hospital or a not-for-profit acute care hospital, they know that they're at the center of care. It really differentiates the very successful orthopedics programs from the not-so-successful programs."

While the Indiana Orthopaedic Hospital only has a small number of the Hoosier state capital's hospital beds, it controls between 25 percent and 30 percent of its orthopedics market.

"We've driven the marketplace in orthopedics," says Mr. Martin. "A dedicated, focused orthopedics facility offers patients a different kind of experience."

For Mr. Martin, that translates not only to patient satisfaction, but increased physician approval as well.

"Doctors can come see patients in clinics, perform surgery and walk through the hospital to make rounds and place orders. They don't waste that two-to-three hours in daily driving, parking and walking between sites. They can be more efficient."

Mr. Martin says streamlining management is another tool that has helped his hospital.

"We can solve problems and address physician concerns easier because there aren't the layers of bureaucracy that slow down decision-making," he explained. "We can do in three or four weeks what takes most acute care hospitals a year to do. The bureaucracy is often what frustrates physicians and leads to disconnect."

3. Focus on quality and profits will follow.

John Reynolds, a consultant for Century City Doctors Hospital in Los Angeles and the former CEO for New York City's Hospital for Special Surgery (HSS), says hospitals should follow the lead of Japanese carmakers whose focus on quality improvement processes helped them to dominate the automobile industry.

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“They succeeded because the quality was there and they used the target of achieving the highest quality to attain profitability,” Mr. Reynolds says. “Doing it right the first time offers a better way to move forward. In healthcare that means you don’t have to go back and do it again. Finding processes to cut infections and reduce complications means cutting your costs, improving patient satisfaction and maximizing profitability.”

He says an orthopedics department can improve profits by cutting length of stay by strictly following quality regimens, protocols and processes, such as infection control systems and clinical pathways.

“By focusing on quality, you improve profits,” Mr. Reynolds says. “There is nothing more valuable to a CEO than getting that bed back one day early.”

Before he retired from HSS, he said that hospital, which has been ranked by *U.S. News & World Report* as America’s best orthopedic hospital, was asked to help the UK’s National Health Service replicate its success with a hospital in London, the South West London Elective Orthopaedic Centre.

“We showed them how, with the same resources, using our methods and efficiency measures, they could achieve success. Now they do two or three times the previous volume with much shorter patient waits,” Mr. Reynolds says.

4. Create and maintain a value analysis team for equipment purchases.

“Our team evaluates and assesses the implants and other devices, materials and equipment ordered and used in the hospital orthopedics department,” William Beaumont’s Dr. Herkowitz says. “We take a pretty hard line and don’t put up with price gouging. We look at different companies with equivalent products and do such a large volume that very few companies won’t negotiate with us and want to be here.”

Dr. Herkowitz says Beaumont’s staff has committed to cost containment and will switch companies if necessary.

“We have to make sure that the price is fair to our hospitals so we can be profitable as well. Our team costs out and analyzes everything we buy, from operating room drapes to sutures and implants. We don’t necessarily go for the cheapest product available, but the product with the highest quality at the best cost,” he says. “We bid out everything.”

Dr. Thomas Sculco, surgeon-in-chief at New York City’s HSS, says profit margins in the pharmaceutical and device industries are high, while margins for most hospitals and health systems remain flat and low.

“Implant costs eat up 30 percent to 40 percent of total reimbursements now for orthopedics,” Dr. Sculco says. “Those companies can’t achieve huge profit margins on our business. Orthopedics departments need to look hard at those costs and negotiate hard. We evaluate all new technologies and manufacturers have to demonstrate those technologies are better and more cost-effective to get our business.”

5. Contractually negotiate compliance with quality protocols and initiatives with public and private payors.

Commercial payors and CMS are piloting pay-for-performance and best practices initiatives that incentivize hospitals to adopt evidence-based practices proven to increase patient safety, reduce errors and improve outcomes. Dr. Herkowitz says his system is cooperating with payors like Michigan’s Blues programs on antibiotics and others quality initiatives.

“By agreeing to administer antibiotics within 24 hours, we’re improving patient care by reducing complications and infections,” he says. “That not only saves us money down the road, but also saves insurers money. And they reimburse us better for the surgeries we perform at the same time we’re improving patient safety.”

6. Adopt and follow effective clinical pathways programs.

“Excellence in quality is a result of how you manage your patients throughout the entire experience,” HSS’s Dr. Sculco says. “Our physicians have input into clinical pathways that offer consistent, quality patterns of care. We document what happens to the patient every day, in some cases, almost every minute. Patient expectations are fulfilled and the throughput is very efficient as a result.”

7. Make patient education a profit center and marketing tool.

Century City’s Mr. Reynolds says his hospital creates pre-admissions plans for patients and offers free classes at least one week before admission.

“We let them know what’s going to happen to them each day and tell them what to expect throughout their stay. When they have pain, they don’t panic. They’re prepared for what happens and that leads to a better, healthier attitude,” he says, noting that discharge processes are much smoother because the patient is prepared.

He says the classes are taught by nurses or physical therapists and are viewed as marketing expenses. “Our length of stay has actually gone down and we view the classes as a revenue driver,” he says. “Patients aren’t mad or anxious about

going home a day or two earlier, but happier.”

Our Lady of the Lake’s Ms. Silva says her hospital’s pre-surgery program includes testing and education, and has resulted in fewer missed appointments and delays.

“We’ve found significant decreases in cancellations and have cut our length of stay,” she says. “Our patients are readier for discharge and we work with physical therapy and home health providers to ensure there’s no fallback in care.”

8. Pre-screen surgery candidates for infections.

“Our pre-surgical screenings for MRSA and other bacteria cost more, but if we find it early, we have pathways for treating it and can reduce problems later,” says Ms. Silva. “We like to get upstream of issues, as opposed to waiting and reacting downstream.”

9. Align incentives.

Consultant Mark Blessing of the Fort Wayne, Ind., office of accounting firm BKD, says hospitals need to work closely with their surgeons to develop initiatives that benefit both parties. Blessing says sharing information with physicians about outcomes, lengths of stay, expenses and



Anna Silva
Vice President for
Ancillary Services,
Our Lady of the Lake
Regional Medical Center

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comparative performance data explains how doctors are doing and helps engage them.

"If the overall goal is to align incentives for hospitals, physicians and patients to get the best outcomes in the most efficient manner, hospitals can work to keep surgery schedules efficient, block time in OR suites and open outpatient surgery centers in locations more convenient and accessible to physicians and patients alike, instead of in distant hospital interiors," Mr. Blessing says.

He says offering state of the art equipment and helping physicians develop cutting edge services cement physician loyalty and encourage them to practice at that hospital. Helping local orthopedics groups recruit new surgeons mutually benefits hospitals and group practices.

Dr. Sculco says HSS physicians are encouraged to participate in cost-cutting programs and can share in the savings incurred, but not individually. At HSS, those savings support department research efforts. "And if the savings can be shared with the department, then that goes a long way to encourage greater participation."

10. Don't just improve market share, but expand and redefine your market.

The Indiana Orthopaedic Hospital's Mr. Martin advises hospital executives to seek new areas and unmet needs for services. Martin says many rural or

community hospitals don't perform enough procedures to justify purchasing expensive equipment and recruiting high-priced specialists and says those facilities may be eager to open new relationships.

"Start looking to different parts of your region where patients lack access to technology and cutting-edge services," suggests Mr. Martin.

He says that while his group hasn't marketed actively outside Central Indiana, he reported that admitted patients throughout the Midwest seek services at OrthoIndy.

"They're coming to us." ■

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oversees corporate operations and performance, formulates and executes the organization's strategy, and represents UHC to the business and healthcare communities and the public. Ms. Cumming joined UHC after serving as president and CEO of the University of Kansas Hospital Authority for 11 years.

3. Delos M. "Toby" Cosgrove — Dr. Toby Cosgrove is the CEO of the Cleveland Clinic. He is a renowned heart surgeon and has numerous patents filed for developing medical and clinical products used in surgical procedures, including the Cosgrove Mitral Valve Retractor, the Stentless Aortic Valve, Low Velocity Aortic Cannula, and the Cosgrove-Baxter Annuloplasty System for use in valve repairs. He has published hundreds of articles and many training and continuing medical education films covering such topics as blood conservation in cardiac surgery and aortic valve repair.

4. Trevor Fetter — Trevor Fetter has served as president and CEO of Tenet Healthcare Corporation since September 2003 and also serves as a member of the company's board of directors. During Mr. Fetter's tenure, he has helped achieve a peace accord with organized labor and resolved all major litigation facing the company. Under his leadership, Tenet has worked to find solutions to the national uninsured challenge; Tenet's Compact With Uninsured Patients has become a model for

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the industry as it provides managed care-type discounts to uninsured patients and ensures they receive treatment, regardless of their ability to pay. Mr. Fetter has also served as the chairman and CEO of Broadlane, a leading provider of cost management services to both investor-owned and non-profit hospitals, and currently serves on the board of the Federation of American Hospitals.

5. Alyson Giles — Alyson Giles is president and CEO of CMC Healthcare System and Catholic Medical Center, Manchester, N.H. She has been president and CEO of CMC Healthcare System since 2002 and president and CEO of Catholic Medical Center since 1999. She also serves as the 2008-2009 immediate past chairman of the American College of Healthcare Executives. Before her current position, Ms. Giles served as executive vice president and COO of Optima Healthcare; president and CEO of New London Hospital; and president and CEO of Lake Shore Hospital in Manchester, N.H.

6. Larry Goodman — Dr. Larry Goodman is the president and CEO of the Rush University Medical Center. He also serves as president of Rush University and is a principal officer of the Rush board of trustees. He is known as an exceptional leader and has developed the system tremendously over the last several years. He has also published in prestigious publications such as the *Journal of the American Medical Association* and the *Journal of Infectious Diseases*. His research has focused on infectious diseases, particularly gastrointestinal infections in HIV-positive patients. He is also known for promoting innovation in medical education.

7. Brett Gosney — Brett Gosney is one of the few people on the list that operates a physician-owned hospital. He is the founder and CEO of the first physician-owned hospital in Colorado, the Animas Surgical Hospital. He is the vice president and president elect of Physician Hospitals of America (PHA). He helped lead the efforts to develop the hospital and fought through a wide range of local and state battles and handled a number of efforts to help make the hospital a terrific contributor to healthcare services in the Durango community.

8. Jeff Hillebrand — Jeff Hillebrand is the extraordinary COO of the Evanston Northwestern Healthcare (ENH) System. Mr. Hillebrand has guided ENH through various and different challenges to become and remain one of the leading hospitals and health systems in Illinois. He previously served as executive vice president, president of ENH Medical Group, senior vice president, and president, of Glenbrook Hospital. He is a fellow of, and has served as a regent in, the American College of Healthcare Executives, and is a member of the Society of Hospital Planning of the American Hospital Association, Leadership Greater Chicago and the Young Presidents Organization.

9. Chris Karam — Chris Karam is a regional leader in CHRISTUS Health, one of the top 10 Catholic health systems in the United States. Mr.

Karam serves as president and CEO of the CHRISTUS St. Michael Health System in Texarkana, Texas, one of the most dynamic regions in the CHRISTUS Health system. He serves on the board of trustees of the Texas Hospital Association and is an officer for the Ark-La-Tex Health Network, which includes approximately 325 physicians and 20 facilities with common goals.

10. Paul Levy — Paul Levy has served as the president and CEO of Beth Israel Deaconess Medical Center, a Harvard Medical School teaching hospital, since 2002. He is the executive dean of administration at Harvard Medical School and previously was an adjunct professor of environmental policy at MIT. He also publishes a blog called "Running a Hospital" in which he shares his thoughts about healthcare.

11. Ed Murphy — Dr. Ed Murphy is the CEO of the Carilion Health System. He is a proactive leader who has helped to transform Carilion System from a traditional not-for-profit model into an integrated physician-driven delivery system. Before joining Carilion Health System and beginning in 1994, he was president and CEO of Seton Health System in Troy, NY. He is also on the board of managers for The Egg Factory, which creates and develops innovations with an emphasis in the space of optics and ophthalmics. He is someone to continue to watch over the next several years.

12. Don Nestor — Don Nestor has served as the senior vice president of finance for the Aurora Healthcare System for as long one can remember. He is responsible for the management of all of Aurora's operations with the exception of those located in the Milwaukee area. He is an unusually gifted leader with a long history of driving the growth of the Aurora System.

13. Mark Newton — Mark Newton is the CEO of the Swedish Covenant Health System in Chicago. Mr. Newton took a leadership of the system approximately three years ago after he completed serving as the president of Highland Park Hospital. During these three years, he has carved out a position for Swedish Covenant as one of the leading systems in the Chicago area and has helped develop and grow the system in a challenging area. Mark also serves on the boards of the Illinois Hospital Association and the Chicago Hospital Risk Pooling Program, and is a member of the advisory board at North Park University School of Business in Chicago.

14. Keith Pitts — Keith Pitts has served as vice chairman of Nashville-based Vanguard Health Systems since 1999 and serves as the chair of the board of the Federation of American Hospitals. Prior to joining Vanguard, Mr. Pitts was chairman and CEO of Mariner Post-Acute Network and its predecessor, Paragon Health Network. He has also served as OrNda HealthCorp's executive vice president and CFO, and has spent more than 15 years as a consultant to healthcare organizations, most recently as a partner in Ernst & Young's healthcare consulting practice.

15. Ron Reed — Ron Reed is the CEO of Mercy Hospital in Iowa City. He helped put together a joint-venture ASC between his hospital and local physicians and has been instrumental in ensuring corporate support while at the same time preserving and cultivating the physician led entrepreneurial spirit of the project. Mr. Reed is on the board of directors for the Iowa Healthcare Collaborative and has been named one of the most influential business leaders in the Iowa City area by a local business publication.

16. John Rex-Waller — John Rex-Waller is the chairman, president and CEO of National Surgical Hospitals, which partners with local physicians to develop freestanding surgical facilities. He has also served as the CFO of Hawk Medical Supply, a provider of disposable medical supplies to physicians and previously he was the CFO and a co-founder of National Surgery Centers which was one the largest independent owner and operator of surgery centers in the country. He has also worked as an investment banker.

17. Michael Sachs — Michael Sachs is the founder of Sg2, a premier provider of data and information to hospital and health system leaders. It generally works with some of the most prestigious health systems in the country. Before founding Sg2, Michael was the chairman of Sachs Group, which provided healthcare planning and marketing data to more than 1,000 institutions in the United States. Michael is a revolutionary thinker and implementer of ideas and a tremendous provider of resources to hospitals and health systems.

18. Molly Sandvig, JD — Molly Sandvig, JD is the executive director of PHA. She has done an outstanding job for physician-owned hospitals and her leadership on behalf of them has been instrumental in the ongoing debate about the rights for physicians to develop and hold ownership stakes in physician-owned hospitals. She also serves as the president of the South Dakota Association of Specialty Care Providers, representing specialty hospitals and ambulatory surgery centers in South Dakota. She is currently serving a second term as a governor appointee to the South Dakota Healthcare Commission. Ms. Sandvig is also a co-chair of the governor-appointed subcommittee on Universal Healthcare Access in South Dakota.

19. Nancy Schlichting — Nancy Schlichting is president and CEO of the Henry Ford Health System. She previously held the positions of executive vice president and COO for the system and was responsible for its hospitals, community care services, hospital joint ventures, physician practice development and integrated support services. She has also served as the president and CEO of Henry Ford Hospital and was responsible for the operation of the Detroit campus. Before joining Henry Ford Health System in 1998, she was executive vice president and chief operating officer of Summa Health System in Akron, Ohio. She has also served as president of the Eastern Region of Catholic

Health Initiatives, president and CEO of Riverside Methodist Hospitals and executive vice president and COO of Akron City Hospital.

20. Wayne Smith — Wayne Smith is the CEO of Community Health Systems (CHS). CHS is the largest for-profit publicly traded health system in the country. Since his arrival in 1997, CHS has grown from \$742 million in net revenue to more than \$4 billion in net revenue. He has done a remarkable job of guiding the company forward in changing times. He also completed the large merger of the Triad System and is doing a terrific job from what we can tell of integrating the two systems together. He has become one of the foremost leaders of hospital systems in the country.

21. Paul Summerside — Dr. Paul Summerside is the chairman of the board of one of the most successful hospitals in Wisconsin, the Aurora BayCare Medical Center in Green Bay. He has been a dynamic leader on behalf of this organization. Aurora BayCare Medical Center is owned in large part by the Aurora Healthcare System. Dr. Summerside is a dynamic and experienced leader. He also serves as the chief medical officer for BayCare Clinic. In this role, he is responsible for all physician relations, recruiting, quality assurance and physician contracting.

He is also a residency-trained and board-certified physician in emergency medicine.

22. John Thomas — John Thomas is president and chief development officer of Cirrus Health. Headquartered in Trophy Club, Tex., Cirrus develops and manages specialty surgical hospitals and ambulatory surgery centers. Before joining Cirrus Health, Mr. Thomas served as senior vice president and general counsel for Baylor Health Care System. John has also served as general counsel/secretary with the Unity Health System, a division of Sisters of Mercy Health System in St. Louis, and as president of wholly-owned captive insurance companies Church University Insurance Company and Health Care Insurance Company of Texas.

23. John Toussaint — Dr. John Toussaint is the former president and CEO of ThedaCare in Appleton, Wis. He recently took the lead on the ThedaCare Center for Creating Value in Healthcare, a new ThedaCare-sponsored effort to promote value-based purchasing. His tenure as president and CEO of ThedaCare was marked by impressive growth as well as growing worldwide notoriety for ThedaCare's success in applying lean manufacturing principles and the Toyota Production System to the delivery of patient care; the process and tools are called the "ThedaCare Improvement System." He was the first chairman

of, the Wisconsin Collaborative for Healthcare Quality and he founded the Wisconsin Health Information Organization.

24. Daniel Wolterman — Daniel Wolterman has served as the CEO of the Memorial Hermann Healthcare System in Houston since 2002. He has more than 25 years experience in various executive positions in the healthcare industry and served as the chairman of the Texas Hospital Association. Mr. Wolterman has taken a high-profile role as an advocate for reducing the number of uninsured Texans. His leadership and advocacy have raised the profile of the uninsured issue and helped build momentum at the state and national levels for meaningful action. In 2007, he received the Partnership for Action Grassroots Champion Award from the American Hospital Association. ■

The Hospital Review

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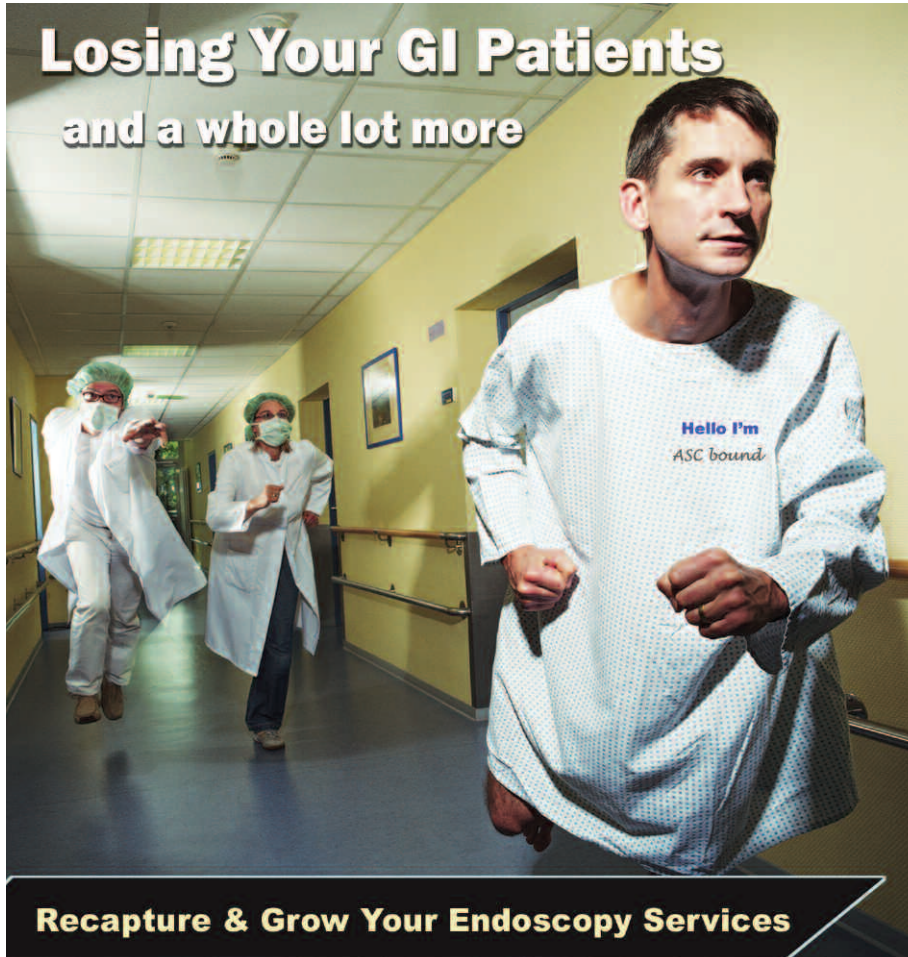
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Hospital Physician Specialists: To Hire or Not to Hire

By Mark Taylor

Hospital hiring of physician specialists ebbs and flows, driven by reimbursement climates.

According to the American Academy of Orthopaedic Surgeons, hospital employment of orthopedic surgeons nearly doubled from 2.2 percent of surgeons in 1990 to as high as 4.3 percent in 2003, but had dropped to 4 percent by 2005, the most recent year for which data was available.

Hospitals face great challenges in recruiting from within a shrinking pool of physician specialists, according to hospital executives, orthopedic consultants and physician recruiters.

The American Medical Association reports that there are only 22,375 practicing orthopedic specialists in the United States, but that figure has remained virtually static. In 2007, 558 specialists completed orthopedic residency programs, compared to 557 in 2008.

Cheryl DeVita, senior consultant with St. Louis-based recruiting firm Cejka Search, says there is a shortage of orthopedic surgeons that isn't being replenished through residency programs. "Of that 22,375, only 8,639 are under the age of 45. The candidate pool is growing smaller. They are in great demand. And unless your hospital is located in a place people want to be, recruiting orthopedic surgeons is going to be difficult," says Ms. DeVita, who pointed out that nearly as many orthopedic surgeons retire annually as enter the field.

When existing arrangements won't help hospitals in recruiting orthopedic surgeons with income guarantees or other incentives, "sometimes hospitals just have to bite the bullet and hire them at the market rate," Ms. DeVita says.

And that's neither cheap nor easy.

In a 2007 compensation survey conducted by Cejka, the American Medical Group Association found orthopedic surgeons, on average, commanded \$436,481 annual salaries, with spine and joint replacement sub-specialists reaping an average of more than \$500,000.

Ms. DeVita says sometimes existing orthopedic groups don't want added competition and won't recruit themselves or are reluctant to pay market rates. Many orthopedic groups won't guarantee that the recruited surgeon will be able to pursue their chosen sub-specialties and are only seeking on-call coverage.

Kellie Risser, a consultant specializing in orthopedics in Columbus, Ohio, says there's only one reason to employ a specialist: "If you can't get one into your market any other way."

Ms. Risser says she hasn't seen hospital hiring of orthopedic surgeons work successfully, noting, "The

specialist who wants to be hired is probably not the one you want."

Harry Herkowitz, MD, chairman of orthopedic surgery at Royal Oaks, Mich.-based William Beaumont Hospitals, says it's appropriate to hire physician specialists in those sub-specialty positions not filled by community-based orthopedics specialists.

"If local, private groups aren't currently offering those services, you might look at hiring someone to take over a sub-specialty not currently covered in your hospital," says Dr. Herkowitz, who cited orthopedic oncologists as an example of a sub-specialty in demand in urban markets.

"Most orthopedic surgeons won't remove tumors, he says. "Also, some smaller community hospitals have difficulty covering trauma services and would otherwise have to send patients to other hospitals offering those services. Under those circumstances it might be advisable to employ a sub-specialist."

But Dr. Herkowitz, who says Beaumont hospitals do not hire orthopedic specialists, acknowledged that there can be drawbacks.

"Sometimes employed physicians have the mindset that they don't have to push that extra bit because they are being paid regardless of how hard they work," he says. "Productivity can be an issue. Doctors on salary aren't always as motivated as those who are paid for the procedures they do."

Victor Dipilla, vice president of operations at The Christ Hospital of Cincinnati, says hiring physician specialists can prove "to be a slippery slope. Once you do it, you have to be prepared for the consequences. This is an issue we're grappling with now."

Mr. Dipilla says it's appropriate for a hospital to hire a specialist when it requires those specialty services, but low reimbursements or high medical malpractice rates make survival difficult in that market.

"Some hospitals are beginning to hoard cardiologists," he says. "Another circumstance might be when you can't otherwise attract those specialists to your hospital and need them. In our case, we're studying this issue."

Anna Silva, vice president of ancillary services for Our Lady of the Lake Hospital in Baton Rouge, La., says hiring specialists should be a last resort. "I personally prefer working with existing community specialists," says Ms. Silva. "But if the quality is not there in the community, or if they exist, but are not engageable, you may have to look elsewhere. It's not my first step, but it is an idea." ■

Contact Mark Taylor at markic46321@yahoo.com.

Minimal to Maximum Integration Models

By Scott Becker

This short article briefly outlines several methods by which hospitals attempt to align interests with physicians. Certain of these options may be useful for different types of projects. Further, depending on whether examining an imaging venture, an ambulatory surgery center venture, a nuclear camera venture, a cardiac cath venture, or other type of venture, certain of the models may be more or less useful. Briefly stated, the core models are as follows:

1. Minimal Integration Models. We generally view the following as minimal integration models. This generally means that the arrangements are short term and generally do not require the development of partnership agreements or require extensive capital contributions.

1) Medical directorships. This involves an agreement with a physician or physician group who will provide various services to the venture (i.e., administrative services, training of employees and staff, etc.) in exchange for a set fee.

2) Management contracts. These are situations where either the hospital would manage a physician practice or a physician would manage a department of the hospital or some other effort on behalf of the hospital.

3) Gainsharing efforts. Gainsharing usually involves the hospital and physicians working together to achieve cost savings in purchasing for certain surgical procedures or other procedures and then sharing those savings between each other. While a minimal integration model, these efforts take a great deal of time and effort to put together.

4) Under-arrangement joint-ventures. In the traditional under-arrangement joint-ventures, a hospital simply buys an existing service from a physician group or similar entity and then bills for the services. This is differentiated from the more extensive under-arrangement ventures being put together today and noted below.

5) Part-time employment arrangements. Here, the hospital or a related party employs physicians on a part time basis to provide services to the hospital.

6) Independent contractor. Here, like an employment agreement, the hospital typically contracts directly with a physician and has him or her provide services on the hospital's behalf. In other independent contract arrangements, such as hospital-based independent contractor arrangements, the physician provides services and bills third parties. Often, there is very little economic difference.

II. Medium Integration Models. We generally view the following as medium integration models. They require more work and effort to put together than a minimum integration model and often require capital contributions and the development of various partnership type agreements.

1) **True joint-venture.** Here, the physicians and hospital joint-venture to be the actual provider of services. The joint-venture provider is developed together. The provider of services bills third party payors and Medicare. This is a typical or traditional model for a surgery center.

2) **Equipment, real estate or infrastructure joint-venture.** Under these types of joint-ventures, the physicians and hospital jointly invest in an equipment joint-venture or real estate joint venture. Then, this venture leases equipment or real estate to either a physician group or a hospital group or both.

3) **Under-arrangements joint-venture.** Under this scenario, the physicians and hospital will often put together a much fuller under-arrangements venture than under the minimal integration under arrangements. Then, this joint-venture will include everything except the provider number and license. Rather than providing services to third parties and commercial payors, it will provide its services to the hospital and the hospital will bill its services as hospital outpatient department services to third parties. These types of under arrangements and joint-ventures involve several serious regulatory risks.

III. Full Integration Models. There are also several complete integration models, which include the following:

1) **Income and employment through hospital directly.** The typical full integration generally includes full and complete employment of the physicians. Here, the hospital directly employs physicians. This has the benefit of satisfying the Fraud and Abuse Statute employment safe harbor and the Stark Act employment exception.

2) **Hospital employs the physicians through a subsidiary.** Here, the hospital creates a subsidiary company and employs the physicians through the subsidiary. Again, this provides the hospital with increased control of its ability to provide services over time and to control the physicians' services.

3) **Professional corporation or foundation model.** Under this type of scenario, the hospital provides services through a captive or related professional corporation that employs the physicians. Here, we note certain recent IRS private letter rulings regarding UBIT in practice corporations owned by hospitals.

Note: This article is not a legal analysis of the models discussed herein. Rather, this is intended as an overview of certain of the options. As one moves forward with any of these options, one should consider the provision of more comprehensive legal guidance, as well as the review of different valuation issues that are involved in each model. ■

Recapturing and Growing Your GI Business

By John Poisson

Hospitals have endured an undeniable decline within their GI outpatient procedural volume in the past 10-plus years as physicians sought alternate settings to perform their cases. This migration of GI procedures from HOPDs to ambulatory surgery centers (ASCs) and GI professional practice settings typically results in a dramatic decline in the overall GI service line market share once enjoyed by local hospitals. In addition, the loss of these outpatient procedures has a ripple effect within the hospital delivery system—numerous other ancillary services traditionally provided by the hospital, such as pathology and radiology, frequently disappear as physicians select alternative providers when their historical referral pattern (and loyalty) to the hospital is loosened.

The good news is that as ASC and office-based settings continue to experience increased regulatory pressures — as well as significant reimbursement challenges — many physicians now seek a relationship with their local hospital. Hospital-physician joint ventures, once the exclusive domain of multi-specialty ASCs, are now increasing within the single specialty GI market. As a result, now may very well be the critical time to implement such a relationship within your market.

In May 2007, a terrific example of just such a hospital-physician endoscopy center joint venture opened its doors. Historically, the GI outpatient department at Montefiore Medical Center (Bronx, N.Y.) performed more than 7,000 ambulatory GI procedures. The 10 to 12 voluntary physicians on staff at Montefiore historically performed more than 6,000 office-based endoscopy procedures within their various professional practice offices, outside the hospital setting. These physicians had left the hospital over the past several years for a variety of reasons, thereby converting much of their GI procedural business to office-based endoscopy units within their own professional practice spaces.

The joint venture between Montefiore and these physicians is called the Advanced Endoscopy Center.

In 2008, the Advanced Endoscopy Center expects to perform more than 10,000 GI procedures within its four-room unit located a few minutes from the hospital campus. Within the next several years, the volume is expected to grow to more than 14,000 procedures annually. Two of the board members of the facility help us understand why this project made sense to pursue.

Why the joint-venture makes sense: The hospital point of view

“As we evaluated the concept of joint venturing with our voluntary physicians, we identified three

primary reasons to move forward with our project,” says Don Ashkenase, executive vice president at Montefiore, whose single-specialty GI ASC opened in May 2007.

1. Identifying core competencies

“Our hospital needs to focus on developing, enhancing and profiting from certain medical specialty core competencies,” says Mr. Ashkenase. “After a comprehensive fiscal analysis, we made the strategic decision that our GI outpatient service is one area that can be effectively managed as a freestanding unit off the hospital campus.”

2. Limited capital budgets

“Our current GI unit’s physical plant needs serious modernization,” he says. “On our urban campus, capital improvements are extremely costly, while developing space off-campus can save significant money.”

3. Enhanced physician loyalty

“GI physicians in the Bronx (as is true anywhere in the country) can effectively convert the vast majority of their outpatient caseload to their existing professional practices,” Mr. Ashkenase says. “Office-based’ endoscopy in the New York City area is highly prevalent. This had already happened right here in the Bronx within our voluntary GI physician group. By developing a freestanding endoscopy center in partnership with our local GI physicians, we effectively align our goals and objectives directly with the physicians in a true partnership arrangement. In this case we regain a portion of the profits from the outpatient procedure business while enjoying increased utilization of our pathology department and other spin-off ancillary business from the facility.”

“Over the past two years, we’ve been impressed with the outcomes of our decision to develop a joint venture project with our voluntary physicians. The facility is good for the community, good for the physicians, and good for the hospital,” says Donald Ashkenase, executive vice president at Montefiore Medical Center, who serves as a member of the board of directors for the Advanced Endoscopy Center.



Don Ashkenase,
Executive Vice
President, Montefiore
Medical Center

Why the joint-venture makes sense: The physician point of view

“Although many members of the voluntary staff at Montefiore Medical Center historically performed a significant volume of office-based procedures in their practices, many of us felt that developing a high

quality state-of-the-art endoscopic ASC would best serve the needs of our patients, while in the longer term ensure reasonable financial stability for ourselves," stated Robert Sable, MD, who serves as the co-medical director at the Advanced Endoscopy Center. There were three primary motivations to develop a joint venture expressed by the physician coalition:

1. Reduced personal risk

Setting up and equipping a quality office-based endoscopy unit is becoming more and more expensive every year. By joining a state-of-the-art endoscopy ASC, physicians can spread their financial risks across a broader spectrum of participants — not just themselves.

2. Reduced personal headaches

Managing an office-based unit takes time and energy, both of which are often in short supply in a busy GI professional practice. By developing a joint venture, using outside expertise as a guide, physician time commitments are reduced.

3. Enhanced relations with the hospital

The traditional physician versus hospital challenges don't have to exist. In a properly structured joint venture (with the right business terms), everyone can co-exist in harmony. Aligned incentives are a wonderful concept. In the case of Advanced Endoscopy Center, an outside management company was chosen to assist in the process, which creates a natural buffer between the hospital and the physicians — an independent third party focused on what is best for the ASC.



Robert Sable, MD
Co-Medical Director,
Advanced Endoscopy
Center

"The center allows a new paradigm for the treatment of our outpatients using a state-of-the-art facility designed to be a center of excellence for our community. I am proud that we were able to do this in a way that strengthens the collegial relationship between hospital based and non-hospital based practices," indicated Robert Sable, MD, who serves as the facility's co-medical director as well as a member of the board of directors for the Advanced Endoscopy Center.

The Montefiore joint-venture endoscopy center demonstrates several important areas that are critical to developing a highly successful joint venture.

- **First and foremost, the ownership of the new facility was strategically designed so that all participants had aligned incentives.** In this case, the aggregate equity of the individual voluntary physician coalition was set at the same level as that of the hospital — each had 40 percent ownership, with the remaining 20 percent minority ownership held by the outside management company tasked with making the venture come together.

- **Governance is aligned.** Both the physician coalition and the hospital hold two board seats, with the fifth seat held by the outside management

company. No single party has effective control over the facility, a point which gives both the hospital and the physicians much comfort.

- **Each party brings value to the table.** The voluntary physicians bring the vast majority of cases to the facility — in 2008, this is projected as approximately 8,000 procedures. The hospital brings strong value to the venture as well. Hospital-employed GI physicians are expected to perform 2,000 cases at the center in 2008. In addition, the hospital's managed care professionals, working with the outside management company, were able to use the hospital's leverage during third party payer negotiations for the new facility. The end result is the center's average collections per procedure is more than double what had been projected in the original business plan.

- **Medical leadership recognizes the two very different types of physicians using the facility.** A co-medical director was selected by both the voluntary physician coalition and by the hospital employed physician group. In this way, the unique needs of both groups are recognized so that the center works for all users.

- **There is opportunity for physician buy-in.** Today's GI physicians coming out of fellowship programs are looking to buy-into endoscopy centers as part of a hiring package. In many cases around the country, income from the endoscopy center distributions exceeds that of the GI practice, primarily due to the declining professional fees within the practice. Although recruitment of new GI physicians was not a primary aspect of the Montefiore joint venture because of the existing GI fellowship program at the hospital, it is very important to many community hospitals. For instance, at Saint Vincent's Medical Center in Erie, Pa., hospital administration recognized the need to recruit new GI providers into the community as their existing physician base grows older. Accordingly, once the new St. Vincent's Endoscopy Center opens in autumn 2008, the facility will provide an important tool for the hospital to attract new GI talent to its staff — the opportunity to buy into the new single specialty GI center.

- **The GI specialty is an in-road to the healthcare system.** GI physicians are typically double-boarded, both in gastroenterology as well as in internal medicine. As a result, a tremendous amount of radiology, pathology, laboratory services, oncology, and a fair number of inpatient admissions, are generated by a typical coalition of eight to 10 GI physicians annually. This is the reason that an increasing number of hospitals are establishing joint venture single-specialty GI ASCs in tandem with their GI physicians, many of whom may not currently consider the hospital their "home" institution. A joint-venture project can bond a physician coalition to the parent hospital, thereby benefiting the hospital through the capture (or in some cases the recapture) of this GI spin-off business.

A parting question to consider: Which would you rather own — 100 percent of the GI outpatient business — which is subject to serious erosion over time as physicians move out of the hospital — or a 40 to 50 percent position in a thriving and growing joint-

venture business in partnership with your GI providers? This is the question many in hospital administration are asking in today's evolving marketplace. Now is the time to evaluate your strategy as you proactively plan for the future. The benefits of the joint venture are many, and the downside is minimal if structured and planned carefully. ■

John Poisson serves as executive vice president and holds a minority ownership position in Physicians Endoscopy, a national development and management company focused exclusively on single-specialty GI ASCs. The company currently operates 15 endoscopy centers with another five projects in various stages of development. Six of these 20 facilities are hospital-physician joint-ventures. He can be reached at (215) 589-9003 or jpoisson@endocenters.com for more information. Learn more about Physicians Endoscopy at www.endocenters.com.

Hospital Leader Shares Insight on Current State of Hospitals and Healthcare

By Rob Kurtz

In just eight years, BayCare Clinic has become an extremely profitable, high-quality, physician-owned organization serving the Green Bay, Wis., community. The chief medical officer for BayCare is Paul Summerside, MD, FAAEM, who also serves as the president of the board of managers for Aurora BayCare Medical Center, in Green Bay.

Dr. Summerside sat down with *The Hospital Review* and shared his thoughts on the major challenges currently facing hospitals, why many hospitals are struggling to find sustainable success and what still keeps him excited about healthcare.

Government regulations hinder growth.

Hospitals are eager to invest in growth opportunities, but the lack of predictability in how future government regulations may impact such ventures is forcing hospitals to limit their investments. Such investments are not cheap, especially when considering the expenses associated with hiring physicians and nursing and technical staff.

"The role of government regulation ... is a massive factor that we have no control over and can change a very good investment into a bankrupt investment with a stroke of a pen," Dr. Summerside says. "It makes us not invest in a lot of things that make sense and have longer payoff horizons because we're not sure if the horizon will ever get there."

Since a solution to the issue of rapidly changing regulatory and payment rules is not in sight, hospitals will struggle to reach their true potential, thus depriving patients of the finest care possible, he says.

"You have a set of rules today that make it very smart to build this or that or develop this business line and a year later, it's bankrupt after you put all of the money into it because someone decided to change the rules. It is a very difficult business reality that I think hamstringing medicine from being as efficient as it could be."

Failure to invest in the "right" physician executives hurts integration. Too many hospital administrative boards are viewing physician executives and clinical leadership as political panderers to pacify their medical staffs, which is hurting effective integration of physicians and fails to encourage collaboration between the hospitals and physicians, Dr. Summerside has observed.

Since physicians can easily move their practice to another hospital or even potentially open a competing practice, integration and collaboration with physicians is crucial to a hospital's success. With much of the success tied to the effectiveness of clinical leadership, hospitals should take a fresh look at the individuals hired to fill these roles and not shy away from investing in these positions.

"I think the systems that will do well are the ones that are able to engage highly competent physician executives, recognize that value and employ them to make the machine work better," Dr. Summerside says. "I would postulate that many healthcare systems struggle because they don't appreciate this."

Hospitals are often looking to fill these leadership positions with less-qualified — and thus lower-paid — physicians. While such appointments may result in financial savings for organizations, when compared to the salary that may be required to hire a physician coming from a more profitable specialty, these individuals brought in to fill these roles lack the experience necessary to bring about positive changes and results.

"So you end up with poor physician leadership, if there's any at all, which perpetuates this kind of laissez-faire medical environment where the specialists have very poor relationships with the hospitals and little integration and little creativity goes on," Dr. Summerside says.

The solution is for hospitals to view these positions for what they truly are: Leadership for the hospital's most expensive and important investment — the physicians. To fill this responsibility, hospitals should recruit a high-level physicians and reward them with appropriate compensation, training, freedom and authority to make the hospital's business work effectively.

"They should identify physicians that are familiar with the high-tech, high-compensation world of a tertiary hospital," Dr. Summerside says. "Who is the most likely to sit down in a meeting with neurosurgeons and orthopods and ER docs that drive the revenue of the hospital and have any credibility?"

"The institutions that can harness executives at that level — the richer will get richer and the poorer will get poorer, and fast. Medicine is way too much of a team game now. All the pieces have to work together very well."

"Transparency" will fail with lack of standardization. "Transparency" in healthcare has been a buzzword for several years now, with growing pressure on organizations to publicize their costs. Unfortunately for hospitals and patients, such transparency could actually serve to deceive patients about what is truly important unless the government develops standard weights and measures for quality and safety.

Dr. Summerside correlates the need for such standardization to that of the automobile industry a few decades ago, when manufacturers did not have to meet extensive safety standards. Manufacturers were free to sell whatever they could and the consumer would purchase automobiles with a belief they were buying good, safe cars.

Then came Ralph Nadar's book, *Unsafe at Any Speed: The Designed-In Dangers of the American Automobile*, which led to *Consumer Reports* and other third-party measurements, and eventually government crash safety tests.

"That's a basic standardized weight and measure, and made the true quality [of automobiles] transparent to the consumer," Dr. Summerside says. "Once that occurred, look at the radical changes in the automobile industry. It had to start with that."

Healthcare presently lacks such a weight and measure, and if organizations merely publicize their prices, and patients (consumers) base their decisions solely on this information, they may be choosing a care provider for the wrong reason.

"If one guy is charging \$700 for a hernia and the other guy is charging \$5,000, and the \$5,000 guy has a 1 in 1/1000 infection rate and the other guy has 10/100 rate, who is really cheaper? How transparent is the fact that you published just the price? That's the fraud the insurance companies and their fee schedule panels have perpetrated.

"I think that if we can truly have honesty about our practices with our patients and our outcomes, that will be the best thing for doctors and their systems," Dr. Summerside says.

He believes the government must become involved and start developing such weights and measures slowly and carefully, even if it is one procedure at a time or just starting with tracking and reporting wound infection rates. Unfortunately, such efforts would require unglamorous grunt work, something politicians are typically eager to shy away from.

Specialties relying on government payors to struggle. Dr. Summerside has seen an ongoing struggle for hospitals to recruit physicians for all specialties, but the struggle is magnified for those relying primarily on government payors. And it is a struggle that will only get harder with continued reimbursement cuts and regulatory restrictions.

"Medicare and Medicaid rates in our environment are unsustainable for things like cardiology, pulmonary, critical care, ER," he says. "If you've got a significant portion of your practice in the government payor arena, you are really going to struggle, at least in this area of the country."

Need for staff forcing tough decisions.

The best of anything is always in short supply, and such is the case with good nursing staff and other hospital staff. Many hospitals are struggling to fill openings and ultimately settling for whatever is available, which is an unfortunate and dangerous trend to start, Dr. Summerside observes.

"We've drawn a line on not accepting poor fits and that can be a hard line, but I tell you, once you get off that position, there is no bottom. If you accept poor performance, it drives all performance down."

Payor consolidation another unfortunate trend. The damage caused by payor consolidation over the past several years, which has the dwindled down the number of payors controlling most contracts to three, or four if you consider Medicare, is terrible news for hospitals and patients, Dr. Summerside says.

"Anybody who thinks the consolidation of these insurance companies is good for the patient or good for cost is nuts. That's a concept that went out with Teddy Roosevelt. That's why the anti-trust legislation was initiated. But the current administration, the Department of Justice, has turned a completely blind eye to this stuff," he says.

Effort and strive for excellence still rewarded. Despite all of the challenges and bad news which seems to impact healthcare on a regular basis, the opportunity for excellent patient care excites Dr. Summerside.

"I still believe, in my heart, despite all of the regulatory crap we go through in the United States of America, if you get up in the morning and you work a little bit harder and a little bit better than the other guy, you will succeed.

Such enthusiasm toward his practice and organization is a significant qualification for anyone hired to join his staff and is the basis of a question he asks prospective physicians during interviews.

"I say, 'if you get up every morning and look in the mirror and you can ask yourself why should any patient come to see me instead of somebody else, if you've got an answer for that, you're going to do great with our group. But if you don't know or you don't care, you shouldn't come here.' If we can keep the right group of guys who get up every morning and give patients a reason to see them instead of somebody else, the patients will be better off." ■

Dr. Paul Summerside is the chairman of the board of one of the most successful hospitals in Wisconsin, the Aurora BayCare Medical Center. He has been a dynamic leader on behalf of this organization. Aurora BayCare Medical Center is owned in large part by the Aurora Healthcare System and is located in Green Bay, Wis. He also serves as the chief medical officer for BayCare Clinic. In this role, he is responsible for all physician relations, recruiting, quality assurance and physician contracting. He is also a residency-trained and board-certified physician in emergency medicine.

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