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TECHNOLOGY

Data in the clouds

HealthLeaders Media

by *Gienna Shaw*

Web-based data sharing is one solution to the interoperability problem—the challenge of communication between healthcare providers, including physician’s offices, hospitals, and specialty practices, which often have different computer and software setups and use a variety of external devices to store and share images. Because everything is online, it’s easy to share simple health data such as patient test results and medical history, and it allows patients access to their records, as well. Cloud computing requires no special equipment—just a computer and an Internet connection.

But when it comes to medical imaging, the massive image files shared in PACS systems can bog down even moderately speedy Internet connections during peak hours—and accessing large files via a dial-up connection is basically a hopeless prospect.

Enter the cloud, a form of Internet-based computing that allows users to share resources, software, and information on computers and other devices on demand.

In addition to being a common, easy-to-use platform that anybody can access, cloud computing has a number of other benefits. Users can share information seamlessly and in near-real time across devices and organizations. It is cost-effective—organizations only pay for what they use. And small physician practices, in particular, appreciate the fact that servers for data storage and management are off-site.

Healthcare decision-makers are interested in cloud computing—two in five say they know at least a “fair amount” about cloud computing, and 49% say their organization has used it, according to a survey conducted by Ipsos Research for Microsoft®. The most common uses of cloud computing across all industries surveyed were collaboration (56%) and storage (48%).

Cloud computing is a common, easy-to-use platform. Users can share information seamlessly and in near-real time across devices and organizations. Organizations only pay for what they use, and small physician practices appreciate the **fact that servers for data storage and management are off-site.**

A number of healthcare organizations, including Seattle Children’s Hospital, South Peninsula Hospital in Homer, AK, and Community Memorial Hospital of Ventura, CA, are testing a new cloud-based technology for sharing imaging studies and reports. San Diego-based eMix™ is vendor-neutral (the organizations testing the system use a variety of PACS vendors) and uses the pay-as-you-go model.

The 944-bed Yale-New Haven (CT) Hospital will use a cloud computing platform to collect and share diagnostic imaging

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information in its new I68-bed Smilow Cancer Hospital and within its trauma unit during emergency transfers from remote locations. The lifeIMAGE™ online medical image platform allows patients, physicians, and hospitals to electronically collect, share, and view diagnostic imaging records from any facility and requires no special equipment or storage devices.

The program uses a diagnostic image management interface that any employee can use to upload or access patient medical imaging information. The images are then transferred to the organization's PACS.

“The ability to load and access imaging information in advance of the patient's appointment [improves] productivity and patient care,” says Michael Matthews, director of clinical imaging and information systems at Yale-New Haven. With more than 500,000 outpatient visits per year, Matthews says, it is critical that medical imaging records are captured and shared as efficiently as possible and that exams are instantly available to all relevant clinicians.

Cloud computing is particularly helpful in image-intense specialties. The Moffitt Cancer Center in Tampa, FL, Memorial Sloan-Kettering Cancer Center in New York City, and Massachusetts General Hospital Cancer Center in Boston use the system to transfer diagnostic images, which patients often carry with them on CDs or other portable storage devices to their first appointment with an oncology specialist.

Hartford, CT-based insurer Aetna® has launched a new cloud computing and clinical decision support solution that combines information from EMRs, claims, medication, and lab data with an evidence-based clinical decision support system. The data are delivered to physicians and patients through an IBM® cloud computing platform.

Sharp Community Medical Group in San Diego is using the Collaborative Care solution to help physicians and nurses access information throughout the group's multiple EMR systems.

“The current state of medicine today is one of paper records, fragmentation, and lack of patient information at the right location and at the right time,” says John Jenrette, MD, CEO of Sharp Community Medical Group. “Unfortunately, this is medicine's current state in most organizations and physician offices. The patient is not engaged

in their own healthcare and not connected to their clinical information and doctors in an effective manner. The work we are undertaking will create a system that is patient-centric. It will provide the connection among primary care physicians, specialty physicians, hospitals, and patients to achieve improved clinical outcomes while reducing costs.”

HealthAlliance Hospital in Leominster, MA, is also using wireless computing and secure Internet access to give physicians access to records, including large PACS files, from almost anywhere and on a multitude of devices. “It's literally available anywhere, anytime. If you have a Web-based link and an account, you can get in,” says Richard Mohnk, vice president and CIO at the I50-licensed-bed hospital.

Additionally, new Wi-Fi™ channels can handle greater amounts of data than earlier versions. The Wi-Fi protocol (802.11n) allows sharing of radiology images, video, and other multi-gigabyte files on more kinds of devices. HealthAlliance Hospital uses that channel with a wireless network solution from Richardson, TX-based InnerWireless.

Cloud overcomes concerns

Healthcare reform will require greater collaboration and communication between providers and with patients. Although government stimulus money will help some healthcare organizations pay for EMRs, the cost of connectivity is still a big issue. Independent practitioners, in particular, are worried. “It's a strain on their pocketbook,” Mohnk says. Cloud solutions, however, are generally cost-efficient. They require no special IT staff to perform maintenance and service, for example.

One issue to consider, though, is time. It takes time to learn a new system, input data, and adjust to changes in work flow—all common grievances among physicians. “The more you can make it so that it's something people can teach themselves, the better off you're going to be,” Mohnk says.

No program will ever be perfect, and it may be a long time before physicians fully adopt electronic data sharing. But physicians that are unhappy even with simpler online solutions are missing out, says Mohnk. Some physicians will readily accept it, some physicians will work to adopt it, and other physicians may never become part of the electronic records world, he says.

Source: Gienna Shavv, HealthLeaders Media, October 13, 2010, online (www.healthleadersmedia.com).

A welcome sign on the road to CPOE and EMR conversion

Medicine on the 'Net®

by Cynthia Johnson

A recent study released by researchers at Lucile Packard Children's Hospital (LPCCH) and Stanford University may be just the signpost we've been waiting to see on the road to computerized physician order entry (CPOE) and EMR conversion.

For the first time, researchers have shown that a significant decrease in hospitalwide mortality rates can be associated with implementing a CPOE system that enables physicians and other medical staff to order medications, tests, and other treatments electronically. If configured properly, the systems can also provide decision support at the point of care.

LPCCH correlated its IT system from Kansas City, MO-based software vendor Cerner® Corporation with a 20% decrease in mortality rates at the hospital over an 18-month period, which amounted to 36 fewer deaths. The hospital launched its IT system in 2007.

"It lends information to the current debate about why you should implement these systems," says Eric Widen, MHA, administrative director of performance improvement at LPCCH. "These systems are very expensive to implement. That level of investment is now justified by understanding that you can have a very significant impact on quality, and that includes mortality rates."

The study contradicts previous findings that had actually shown an increase in mortality rates after CPOE implementation, including a landmark publication that Children's Hospital of Pittsburgh published in the December 2005 *Pediatrics*.

"We compared ourselves to 42 other children's hospitals who submit their mortality data to the Child Health Corporation of America database," says lead author Christopher Longhurst, MD, medical director of clinical informatics at LPCCH and clinical professor at Stanford. "In 2008 and 2009, we became the single lowest-adjusted mortality facility of any of these other 42 hospitals." According to Longhurst, the authors of the study were pleased when mortality rates began to decline nine months after implementation. When they continued to decline after 12 months and then 15 months, authors went back and ran their statistics to verify the significance of their findings. At

that point, they decided they needed to conduct a study to share these revealing data with other sites, he says.

Saving lives by saving time

Using the system to reduce unnecessary wastes of time was the biggest catalyst to lowering mortality rates at LPCCH. When the hospital studied its turnaround times for laboratory, radiology, and medication orders, it found a significant decrease in the time from when a clinician placed an order to the time someone acted on it by conducting a radiology exam or administering medication. "There's a lot of waste in the system associated with paper orders that involve faxing, tubing, or people having to find the order rather than having it pop up automated on a work list," says Longhurst. "In some of those cases, we cut those turnaround times in half. It's not hard to imagine that getting medication to a critically ill child five or 10 minutes faster can actually have an outcomes impact."

Speeding up order entry processes not only results in faster order completion, it also helps hasten a physician's access to laboratory and radiology results, says Widen. "We think it has a benefit for those highly acute patients who require fast decisions," he says. "This gives our physicians quicker access to information."

In addition, all of the nursing and ancillary service documentation is available to physicians electronically. "That makes our vital signs and patient physiologic data available in real time throughout the hospital and outside the hospital," Longhurst says, adding that the availability of that information could have also contributed to the mortality reduction.

Source: Cynthia Johnson, *Medicine on the 'Net*, November 1, 2010, online (www.healthleadersmedia.com).

FINANCE

Charged up about chargemaster automation

HealthLeaders Media

by Karen Minich-Pourshadi

Here's a CFO pop quiz: What is the one often-overlooked linchpin in the revenue cycle?

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If you answered “the chargemaster,” then you’re correct.

It’s easy to forget just how important your chargemaster is, especially with all the other revenue cycle components you have to watch. But if there’s one area you can’t afford to take your eyes off of, it’s the chargemaster. With every revenue transaction funneling through it, the chargemaster has the potential to bring in or cost your hospital millions of dollars. Given that, why do so many hospitals still use a manual process when an automated one will save time and money?

When you stick with a manual process, errors due to absent or incorrect information are often identified downstream—past the point of the original transaction. Moreover, there are thousands of changes to coding rules each year, and with many hospitals using a chargemaster with up to 40,000 line items, it’s impossible to think that a chargemaster could be correctly updated manually. A manual chargemaster also leaves financial leaders without the ability to pinpoint specific sources of errors, which ultimately leads to reimbursement delays, reductions, and denials. Quite simply, anything with the level of detail, complexity, and routine maintenance of your chargemaster has too many variables, which can translate into revenue leaks for your hospital.

It’s been estimated in more than a few healthcare reports that providers lose millions of dollars annually due to errors in claims data—errors that are often traced back to the chargemaster. Traditionally, stopping a leak comes from management efforts focused on revenue operations and audits. Those are excellent tools, but what about revenue integrity?

Revenue integrity strives to prevent risk reoccurrence and lessen its impact. As any doctor will tell you, it’s better to prevent illness than to treat it. In this instance, preventing problems means you must use technology to your advantage. You need to make process improvements such as teaching staff to use the technology you have more adeptly, creating and following best practice rules, and ensuring correct payment through proper pricing, charging, coding, and documentation.

The above is not advocating unnecessary spending. In reality, automating your chargemaster is as vital to the health of your hospital as having great physicians and top-notch

medical equipment. Just ask Doug Barry, vice president of revenue cycle and HIM at Glen Falls (NY) Hospital.

This 400-bed hospital—the largest one situated between Albany, NY, and Montreal, Canada—includes a main acute care hospital campus, 28 healthcare facilities, and a service area that stretches across six primarily rural counties and 3,300 square miles. The breadth of Glen Falls’ coverage area means that many of the services it provides do not generate enough revenue to pay for themselves—a situation to which many other facilities can relate. For Glen Falls, optimizing revenue is critical, which is why in fall 2009 the facility decided to invest a six-figure sum into automated revenue integrity software.

When the market tanked, Glen Falls Hospital went through the same budgetary overhaul that many hospitals nationwide did; however, at the end of its process the facility had cut its highly skilled chargemaster employee. Recognizing this error, Glen Falls promoted from within, but it still needed to train this person and provide the tools to discern where its revenue was leaking.

It was time to automate. After researching and talking with various vendors, the facility landed on Craneware®, based in Atlanta.

“We needed this software for continuity and consistency. For us it was the absence of the intellectual capital [that made us realize] we needed to automate this process,” says Barry. “It’s an area with a high volume of activity; you need to have a control point.”

Prior to taking the software live, Barry’s team trained on it. What did they find? Along with improvements in their ability to efficiently price, charge, and code for services, their reporting and data mining processes went from being a weeklong effort to taking three to four minutes.

Moreover, the software flags exceptions to industry best practices and allows hospital staff to manage those exceptions rather than getting mired in complex details. It also enables staff to identify the exact sources of the problems and correct them before they become patterns of behavior within the charges—a much more efficient approach than correcting the same errors over and over again later, after claims have been denied or rejected. Additionally, the automated process allows providers to see losses of revenue that would be missed by traditional scrubbers.

“Just 12 months prior to adding the Craneware software, we had a consultant check our chargemaster and we were told that it was in relatively good shape, but what we found intriguing was that the consultants never talked about the things we were not charging for,” says Barry. “This software is doing a better job of identifying opportunities.”

Indeed, automating the chargemaster has given Glen Falls’ bottom line a boost—it has been able to identify more than a few opportunities over the past year.

Certainly, financial leaders have a lot of cost-cutting measures on their minds, and the supply chain offers the easy target; however, automating your chargemaster has the potential to unveil millions of dollars in reimbursement. It’s not low-hanging fruit, but you may find it’s a more ample harvest.

Source: Karen Minich-Pourshadi, HealthLeaders Media, November 1, 2010, online (www.healthleadersmedia.com).

Risk reduction strategies healthcare finance leaders can use to minimize financial exposure

Health Governance Report

by Karen Minich-Pourshadi

With all the rapid changes taking place due to healthcare reform and the economy, many healthcare finance leaders are grasping for any way to minimize their financial exposure—and that means assessing risks that are more likely to generate financial losses. As the payment environment changes in the coming years, healthcare facilities must become extremely adept at identifying, measuring, monitoring, and ideally eliminating their risks, or they may lose greatly needed revenue.

Most industry leaders foresee several payment and quality initiatives taking an even stronger hold in the coming years, including price transparency, consumer-directed health plans, bundled payments, P4P programs, HSAs, and CMS payment incentives. Regardless of which of these ideas win out, a greater emphasis will be placed on the quality and value of healthcare services with a demand for transparency of service price.

So where should finance leaders look for risks, and how should they approach them? Two good places to start are revenue cycle and quality and safety programs.

St. Vincent Health in Indianapolis, part of Ascension Health, oversees the revenue services for 19 hospitals in the system—an area that is generally rife with risk of financial loss. With \$2 billion in total net revenue, Gregory Snow, vice president of revenue cycle for the system, and his team must be vigilant about managing negative influences on the payment environment. Traditional prescreening is part of the approach; however, to offset the risk of losing revenue, they are also using technology.

“The first access to St. Vincent’s enterprise is patient scheduling, followed by a series of preservice clearance functions, which include verification of coverage, insurance benefit levels, out-of-pocket estimates, need for financial assistance, and confirmation of the patient’s appointment,” says Snow.

The facility uses MedAssets’ Charge Capture Audit or CCA.net, which looks at the procedure being billed and then assesses whether all the other possible services have been billed. For example, say procedure X is frequently accompanied by procedures Y and Z. If a physician performs procedure X, and Y and Z were performed but hadn’t been billed, the facility can add those charges once the documentation is reviewed and verified. Within the first 10 months of using this program, St. Vincent saved \$3.4 million on 2 million claims.

The system also runs a risk segmentation analysis to determine a patient’s ability to pay after services have been rendered. Using software from Passport Health, staff can verify eligibility, benefit levels, and coverage; this has helped reduce denial rates. It enables St. Vincent to set up payment terms with the patient in advance of a procedure, as well as offer any discounts.

“The vast majority of patients want to pay their bills, but especially over the last couple of years, people just need assistance. By adding programs that are flexible and meet patient needs, we are also building a loyal customer,” Snow says.

Quality programs stem losses

Although revenue cycle is the most obvious area to examine for financial risk, analyzing clinical risks and making

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quality corrections can also garner financial savings. At the 2,000-bed Spectrum Health in Grand Rapids, MI, Joseph Fifer, vice president of hospital finance, and John Byrnes, MD, senior vice president of system quality, have been concentrating on reducing financial risks, and ultimately financial losses, through clinical quality improvements tied to staff salaries.

With seven hospitals, 16,000 employees, 1,500 physicians, and annual payroll and benefits amounting to \$734 million in 2009, reining in risk and cost are challenging priorities. So, approximately eight years ago, the system took a look at its quality and safety program and decided it needed to be reinvigorated.

“We set up quality measurements and we used an existing database for the quality reporting. We began reviewing the high-volume and high-cost medical procedures,” says Byrnes.

To get the program going, Spectrum Health assembled a quality improvement team led by nursing and medical directors and a financial analyst, who was assigned to look at complication rates, not profits and losses. The goal was simple: Reduce the complications as much as possible.

The team also ensured that the quality and safety goals were embedded in the system’s strategic plan as well as in the providers’ compensation plan. They then took this initiative one step further and added a quality evaluation as part of the staff’s annual evaluation and salary adjustments.

“We assigned key performance indicators to each director and manager, which they and their teams would have a direct impact on, then we tied meeting these goals to their annual review process,” says Byrnes.

Rather than use clinical benchmarks, 25%–30% of the review and salary calculations were based on quality and safety metrics. Additionally, as an added incentive, two sets of goals were measured: a baseline and a stretch goal of 150% of the baseline. “It was a strong motivator,” says Fifer.

“But if we only focused on the financial impact of doing this, we’d have lost the engagement of the clinical folks, and that’s critical to the program’s success,” adds Byrnes.

Just by decreasing four specific complications associated with the cath lab, the system realized an ROI of \$1.4 million. Since it began, Spectrum Health’s program has concentrated on clinical quality and safety; however, recognizing the changing payment landscape ahead, the system intends to more intensely track the financials connected to the program.

The organization is also piloting the Prometheus Payment[®] initiative, which is testing bundled payments based on evidence-informed case rates for acute and chronic illnesses (e.g., acute myocardial infarction, hip replacement, congestive heart failure, diabetes, asthma).

“The financial analysis doesn’t change the agenda at the hospital, but if you can get that ROI on the reduction of complications and the improvement on safety, that plays an important role in managed care contracting,” says Fifer.

Source: Karen Minich-Pourshadi, Health Governance Report, November 2010, online (www.healthleadersmedia.com).

QUALITY

Rethinking the future of outpatient chronic care

The Doctor’s Office

by Janice Simmons

The next 20 years could be thought of as the next great migration—when 77 million Americans, the biggest group ever, move through the window for ages 55–75. It’s the baby boomers and generation Xers getting older, bringing with them new challenges and pressures inside and outside the healthcare system.

“That window is the highest period of healthcare utilization for the average American. It’s when most chronic diseases manifest,” says C. Martin Harris, MD, MBA, CIO at Cleveland Clinic.

At the same time, the number of physicians and physician offices is not expected to keep pace to provide for that demand for care. “Our ability to deliver the care in the same model that we have today is going to be very tightly constrained—if not impossible,” Harris says. “There are many reasons now to start thinking about how we can deliver this care in a more effective manner going forward.”

The current medical model treats chronic disorders, such as hypertension or diabetes, as though they are episodic, calling for visits to a physician perhaps three or four times per year, Harris says. “If we could start to manage it in a more continuous way, then we could affect the quality of the care we’re delivering—essentially because we could make more adjustments at more appropriate times.”

To address this, Cleveland Clinic decided to better track chronic conditions, coordinate treatment, and schedule timely interventions.

In December 2008, the clinic, working with Microsoft®, started a physician-driven pilot project to follow patients with multiple chronic diseases in a clinical setting. The hospital paired its EMR system with Microsoft’s online HealthVault™, a Web-based storage platform, to monitor patients’ health conditions.

More than 250 participants enrolled: 26% with diabetes, 6% with heart failure, and 68% with hypertension. The patients used at-home heart rate monitors, glucometers, scales, pedometers, or blood pressure monitors, depending on the disease, to follow their conditions. The devices uploaded the patients’ data, which then would be connected to the physicians’ EMRs and to the patients’ PHRs.

In results released earlier this year, the project found a change in the average number of days between physician office visits for patients. Diabetic and hypertensive patients were able to make doctors’ visits less often—increasing the number of days between appointments by 71% and 26% respectively. This indicated that patients had better control of their conditions.

However, heart failure patients visited their doctors more often—decreasing the number of days between visits by 27%. This indicated that patients were advised to see their healthcare provider in a more timely manner to avoid complications and stay out of the hospital.

“This [telemedicine] concept has been around, but when it was done a decade or so ago, it wasn’t done with technology; it was done by calling patients at home. It worked but was cost-prohibitive,” Harris says. The current project required no extra practitioners. “We just built it into their work flow.”

The big challenge will be getting reimbursement systems to reflect this kind of model of care. “There’s no question

in my mind that reimbursement systems today are based on the old model of care, which is we get reimbursed when the patient is sitting in front of us,” Harris says. “Part of this study is to demonstrate we can deliver high-quality care and we can do it at lower cost.”

Medical home model

At the Vanderbilt Medical Group and Clinic in Nashville, one question sticks in the mind of Jim Jirjis, MD, the chief medical informatics officer: At the end of the day, do people want to pay today for the benefit tomorrow?

For those who are the sickest of the sick, the answer is simple: Yes, it makes sense to help that population, Jirjis says. But what about that middle territory, where individuals aren’t really ill yet, but could be in the very near future if they don’t get appropriate care now? This includes treatment for chronic conditions such as high blood pressure, diabetes, or congestive heart failure.

The future primary care system will not have anywhere near the capacity to take care of all those chronically ill patients under the old model, says Jirjis, who is now implementing a medical home pilot using Vanderbilt’s home-grown EMR that can assist in data mining and decision support.

Jirjis says this new model looks at providing “advanced stratification” for various chronic conditions. Rather than simply labeling patients “hypertensive,” for example, they are grouped into one of five categories: prehypertensive, new diagnosis, established but controlled, newly out of control, and ill with comorbidities.

“The reason we make those distinctions is that they require different levels of intervention,” he says. In the current medical model, hypertensive patients often fail to make a physician appointment, or no one keeps in touch with them between physician visits. This model is cheap now—when care is delayed or nonexistent—but can rapidly inflate with time.

Instead, if efforts are made to provide care at the appropriate intervals and make sure conditions are monitored, patients’ conditions will be prevented from deteriorating. In the average practice, about 40%–50% of patients have their high blood pressure under control. Using a proactive

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approach, this rate can increase to 80%. That improvement translates into fewer strokes and heart attacks. Using mathematical projections, Jirjis predicts that in a group of 10,000 hypertensive patients, approximately 37–40 fewer heart attacks or strokes would occur over a five-year period, translating into several million in savings during that time.

These savings could be reinvested back into the practice to help supply other providers, including nurses or physician assistants, to provide ongoing care. “We should be able to double our capacity of patients,” Jirjis says.

Self-management is an area that could receive additional attention among the chronically ill population, says Shirley Moore, PhD, RN, a professor of nursing at Case Western Reserve University in Cleveland and director of its Self-Management Advancement through Research and Translation Center.

“Promoting self-management of health ... can have some great downstream effects in terms of mitigating problems with chronic illnesses,” Moore says.

“Medication adherence is a huge area” that could benefit populations with multiple chronic illnesses because of the number of medications they are on, she adds.

Source: Janice Simmons, The Doctor’s Office, December 2010, online (www.hcpro.com).

Managing population health

H&HN Magazine

by Howard Larkin

Bon Secours St. Francis Health System is both a healthcare provider and operator of a large employee health plan, so improving the health of its local population is top of mind.

“As a provider, we have focused on disease care, and we want to be a provider focused on healthcare,” says Johnna Reed, vice president of cardiovascular services at the Greenville, SC–based system. “As an employer, we recognize our current system is not sustainable. It is costing more and more, but it is not generating better health outcomes.”

So Bon Secours partnered with Greenville-based Michelin North America to develop a pilot program that would come

up with ways for patients, purchasers, and providers to both improve health and reduce costs.

“If we want to address value in healthcare, the issue to address is population health,” Reed says.

According to Michael Bilton, executive director of the American Hospital Association’s Association for Community Health Improvement, hospitals that undertake this kind of project should identify a target population and their specific health needs and then deploy interventions and prevention programs.

“The interventions target individuals, but they affect the entire population,” Bilton says.

So diabetes patients were Bon Secours’ target population. “Diabetes has the broadest impact. If we could do it well, we could affect all kinds of related disabilities, like blindness and vascular disease, and improve absenteeism,” Reed says. The pilot has enrolled 30 Bon Secours employees, and so far one group of patients has lost a total of 45 pounds. Others are successfully managing blood sugar through an outpatient program with fewer physician visits.

“It will take years for us to know the full benefit,” Reed says. Nonetheless, she adds, she believes the approach will pay off.

Assess and address

The concept of population health management isn’t simply the focus of Bon Secours, however; it’s a big part of healthcare reform, such as basing reimbursement on system outcomes. The law also requires tax-exempt hospitals to conduct community health needs assessments every three years.

With all this in mind, it’s critical that big businesses get on board.

“More and more employers are actively pursuing preventive health and productivity enhancement. It is growing across the board,” says Helen Darling, president of the National Business Group on Health (NBGH). Half of employers with the NBGH have revamped their health plans or are planning to do so within the next year, according to a survey by Towers Watson.

As a result, hospitals will need to coordinate services across a continuum of care and track information about which interventions patients receive. They will also have

to understand the needs of communities and populations beyond their own walls.

“The great change in the healthcare business model is to reward promoting health,” says Jeff Etchason, MD, chair of the department of community health, health studies, and education at Lehigh Valley Health Network in Allentown, PA. “Reimbursement policy will gradually shift away from fee-for-service to a capitated system or bundled payments. It is a real sea change.”

Lessons learned

The diabetes pilot project at Bon Secours has required a multidisciplinary approach that incorporates doctors from several specialties, dietitians, exercise physiologists, and health coaches.

But instead of sending patients to disparate providers, the Bon Secours pilot uses a provider team for group visits.

“We colocate the team in an environment that is dedicated to chronic health,” Reed says. The initial appointment takes half a day, beginning with dietitians guiding participants through food choices. Then the group meets to discuss the life issues they share.

Although some clinicians were skeptical at first because of confidentiality concerns, the results soon changed their minds.

“The patients were great with it,” Reed says. “The physicians and nurse practitioners were taken aback at how they would share about sexual dysfunction and personal life issues that were barriers to managing their diabetes. One physician said he learned more in the group meeting than he had in 11 years of treating one participant.”

The program has also shown the importance of treating the psychological aspects of diabetes. “The single most important lesson we have learned is the most valuable member on our team is the psychologist,” Reed says, since many patients receive little support at home, are often their household’s primary caregiver, and may be depressed. But getting psychologists was difficult, since diabetes is viewed as a medical problem and reimbursement rates were low: about \$68 an hour.

“As employers, we addressed it. We increased it to \$150 an hour because that is what they command in private practice,” Reed says.

Source: Howard Larkin, H&HN Magazine, October 2010, online (www.hhnmag.com).

LEADERSHIP

Managing millennials

Inc.com

by Leigh Buchanan

Amy Gutmann, a political theorist, has been president of the University of Pennsylvania since 2004. Inc. editor-at-large Leigh Buchanan asked her how what’s happening on campus now will affect businesses down the line.

Inc: A lot of people seem to think the current crop of students—the so-called millennials—is a new species that must be trained and managed in new ways. What have you found works in the classroom?

Gutmann: One of the characteristics of millennials, besides the fact that they are masters of digital communication, is that they are primed to do well by doing good. Almost 70% say that giving back and being civically engaged are their highest priorities. We see this in the classes they select. For example, they flock to academically based service-learning courses. That’s where they get credit for doing projects out in the community, like helping the American Cancer Society to develop a new fundraising model. So to the extent that employers can, they should offer work that in some way contributes to society.

Inc: Those are pretty high expectations. Won’t these graduates be in for a rude awakening when they enter the workforce?

Gutmann: The key with the millennials is to provide structure for them in the workplace and at the same time find ways to channel their energy, engagement, and desire to help solve problems. It’s up to businesses to provide opportunities that drive profit while also encouraging these young professionals to take on ever-larger challenges and apply what they’ve learned.

Inc: Any ideas on how employers might do that?

Gutmann: The millennials want to be out in the field with clients where they can work in teams and solve problems collaboratively, not just sit at desks. And they

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expect to be rewarded for their creativity and productivity. A lot of very prominent businesses have found that offering new, extremely talented employees the ability to do pro bono work and to do something that has high social impact is a big draw. So pro bono work is no longer something that is pushed off on your least talented employees, but has become something used to reward your most talented.

Inc: With the job pool so shallow, many new grads are opting to stay in school and pursue advanced degrees. Does that foretell a future of companies with supereducated staffs?

Gutmann: I think the last decade was unusual in that students had such large incentives to go straight out into the workforce, particularly in consulting and finance. That meant fewer students entering graduate and professional schools. We are seeing signs of improvement in hiring—recruiters on Penn’s campus have increased over the last recruiting season. But we’ve also seen an increase of 30% in applicants to our schools of engineering and applied science and nursing. More students are going to law school.

Inc: If more people have advanced degrees, does that place downward pressure on the premium employers pay for such backgrounds?

Gutmann: The premium on having an advanced degree has increased over time. Even if that increase slows down, it is very unlikely to disappear.

Inc: What are universities doing to develop the kinds of leaders businesses will need?

Gutmann: Leadership is rarely learned from a book. It is learned from practicing with excellent mentors and role models. That’s why a lot of leadership education goes on outside the classroom. Students mentor other students, consult with nonprofits and small businesses, start ventures on and off campus. At Penn, Wharton professor Michael Useem teaches leadership in the classroom, but he also takes students and business people on mountain-climbing trips, where they work together to achieve goals under challenging conditions. That’s a great metaphor for leading a business forward.

Source: Leigh Buchanan, Inc.com, August 24, 2010, online (Inc.com).

The four C’s of a career move

Healthcare Informatics

by Tim Tolan

When you’re contemplating a career move, it helps to have a standard by which you can measure the potential value of a new position. Use these 4 C’s to create four standards for accepting a new position:

1. **Culture.** Speak with current employees to really get an understanding of the culture of the company. New recruits should also ask the hiring manager a few questions during the interviewing process, such as, “What is it like to work for you?” and, “What is your management style?”
2. **Career progression.** Think about whether this position will help you attain your career objectives in the next five or six years. Make sure you find a role that doesn’t just fatten your wallet—instead, find one that matches your career goals and puts you closer to reaching your long-term objectives.
3. **Chemistry.** Did you have a positive interaction with the hiring manager? How did it make you feel? If possible, schedule a post-interview, follow-up meeting, preferably outside of the office. Ask to meet the hiring manager for lunch or dinner to be sure the chemistry is there.
4. **Compensation.** Believe it or not, this C is last on the list. Check this box last when evaluating a new opportunity. If all the other elements under consideration are positive, then consider compensation. Don’t go chasing compensation as the most important aspect of the career move. A good offer should increase your base salary, but the salary should not be the end-all. If you let money trump the other elements of your decision, the bigger paycheck may not be able to make up for a bad working environment.

Source: Tim Tolan, Healthcare Informatics, November 2010, online (www.healthcare-informatics.com).

MARKETING

Open heart surgery webcast draws viewers

Healthcare Marketing Advisor

by Marianne Aiello

The television dramas that follow the fictional stories of hospital doctors and staff have always scored high viewer ratings. But more recently, a growing number of shows are devoted to disseminating accurate health information and depicting real procedures, such as *The Doctors*, *Dr. Oz*, and ABC's *Boston Med*. Memorial Health Care System in Chattanooga, TN, recently tapped into this trend by creating a video of an open heart surgery, which also featured interviews with the patient, her family, and a live chat with the surgeon.

The popularity of these kinds of medical shows “provided a platform for discussion on how to reach a broader audience with a webcast of a procedure and incorporate the ability to talk with a physician and have questions answered,” says Lisa McCluskey, vice president of marketing and communications at Memorial.

The 405-bed system began streaming videos on its website in 2008, which averaged about 1,800 views each month. But for this project, marketers decided to partner with the *Chattanooga Times Free Press* to host the video on its site.

To set the wheels for the video and webcast in motion, McCluskey first had to find a heart patient and surgeon who were willing to share their stories. “Lisa had lined up the patient, who agreed to let us talk to her family before the surgery, so we were able to get a small crew to interview the patient’s family before the surgery and also interview the patient’s family after the surgery,” says Tim Roberts, vice president and creative director at Franklin Street Marketing, a Richmond, VA, agency.

“We also were able to conduct an interview of the physician as he was scrubbing up to talk about the real benefits of this surgery,” Roberts says. “We had to think about it beyond the operating room, and we were able to piece together the parts of the story so it’s one continuous story.”

Although the surgeon who performed the operation was initially wary, he became enthusiastic once marketers explained the benefits of the webcast.

“The concept of doing a surgery video is a wonderful way to [promote the heart program] because it is dramatic,” Roberts says. “That helped Lisa in terms of getting buy-in from the surgeon and the hospital in general. They were very forthcoming in trying to look for ways to share info about the surgical process.”

After the patient and surgeon agreed to be featured in the video, marketers had to decide the best way to broadcast the event. “Originally we talked about it being a truly live streaming video event, and then I think common sense took over and we thought, ‘Well, a lot could go wrong with this,’” says Stephen Moegling, senior vice president of client services at Franklin Street. “So we opted to do a prerecorded video of a complete surgery that we edited down, but with a live portion.”


Marketers promoted the webcast via print ads in the *Times Free Press*, online advertising on www.timesfreepress.com, a 15-second spot on the local NBC affiliate, traffic tags on NBC and CBS affiliates and 18 radio stations, an article in *Chatter* magazine, and in Memorial employee and physician newsletters. In fact, Memorial advertised the webcast so well that the initial airing on September 15 had some technical difficulties.

“At the start of the video, we pulled 97 MG of 100 MG available bandwidth, which necessitated some technical maneuvers to cause the video to run smoothly and created a 20-minute delay in the launch,” McCluskey says. “As we launched, there were 2,800 IP addresses logged on for the webcast.”

Memorial doesn’t know exactly how many people viewed the webcast when it originally aired, but due to the many classrooms and other groups gathering to watch together, Moegling estimates it was in the tens of thousands.

“We were aware of many schools that had classes of students logged on,” McCluskey says. “We had calls from people visiting family in the hospital who wanted to see the video and many physician offices that intended to stream for staff. Many former patients logged on and chatted, thankful for the opportunity to tell Dr. Morrison how well they are doing and for seeing what happened during their surgery.”

Because this webcast was so successful, Memorial marketers plan to do quarterly web-streaming procedures, with the next one occurring in January and focusing on a diagnostic catheterization and bypass grafting.

Source: Marianne Aiello, *Healthcare Marketing Advisor*, October 2010, online (www.healthleadersmedia.com). 

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MHA bans hiring of tobacco users

The Massachusetts Hospital Association (MHA) will no longer hire tobacco users, sending a very public get-tough message that it hopes will resonate with other employers looking to reduce healthcare costs.

MHA president and CEO Lynn Nicholas says the trade group for more than 100 hospitals in the Bay State decided to go public with the ban—which took effect January 1—to raise awareness about the No. 1 cause of preventable death in the United States. Nicholas unapologetically concedes that the ban on hiring smokers follows an “all stick and no carrot” mantra because she believes sticks are more effective when it comes to discouraging smoking.

“We have had the carrots out there for years. I was in a debate with someone from the business community, and they said it’s all about carrots. Au contraire!” she says. “What has caused people to quit smoking is public awareness, but more so the cost of smoking has gone way, way up, and the prohibitions on smoking on public places make it really hard to find a place other than your car. That is what has driven it. Those are all sticks.” Nicholas notes that MHA and its 45 employees also have an obligation to provide a high-profile role model for healthy living and to find ways to reduce soaring healthcare costs.

Smokers are not a protected class of workers, Nicholas says, so there is no fear of violating federal law with the ban, which will not affect

MHA employees already on the payroll. Although Massachusetts state law permits the ban, the National Conference of State Legislatures said that 29 states ban discriminatory hiring policies aimed at smokers.

Source: HealthLeaders Media, November 8, 2010, online (www.healthleadersmedia.com).

EMR alert reduced use of blood test

An electronic message sent to physicians the moment they ordered a blood test for elderly patients reduced unnecessary use of a test that is often falsely positive for the elderly, according to a paper published in the *American Journal of Managed Care*.

The D-dimer test, combined with a clinical risking algorithm, can help in the diagnosis of deep vein thrombosis and pulmonary embolism, but it’s only 35% accurate for patients aged 65 and older. This can result in numerous false positives and additional, unnecessary testing. The study is among the first to look at the effectiveness of an electronic alert for a specific condition in a specific patient population.

In the study, physicians received an alert in Kaiser Permanente’s EMR. The alert explained the inaccuracy of the test for this age group and suggested using a radiological test as appropriate. As a result, the rate of these tests for patients over 65 decreased.

Source: American Journal of Managed Care, November 4, 2010, online (www.ajmc.com).

Rx spending, quality not equal

Medicare patients in regions that spend the most on prescription medications are not necessarily getting better-quality care, according to a study of spending practices from the University of Pittsburgh Graduate School of Public Health. The findings also show great variation across the country in both drug spending and the rate of inappropriate prescriptions for the elderly.

Using pharmacy event and medical claims data as well as ZIP code information for more than 500,000 Medicare beneficiaries, the researchers determined there was broad variation across regions in the quality of prescribing after adjustment for demographic variables and level of health risk. For example, at the top of the scale, 44% of elderly beneficiaries in Alexandria, LA, used high-risk drugs while only 11% in the Bronx, NY, did. Regions where beneficiaries were more likely to be given prescriptions for high-risk or potentially harmful drugs did not necessarily spend more on drugs overall than regions where beneficiaries were less likely to use high-risk or harmful drugs.

Source: University of Pittsburgh Graduate School of Public Health, November 5, 2010, online (www.publichealth.pitt.edu).

One in 10 hospital admissions avoidable

Nearly four million hospital admissions in 2008, roughly one in 10, could have been avoided if acute conditions or chronic diseases that

provoked hospitalization were prevented or better managed, according to a report from the Agency for Healthcare Research and Quality (AHRQ).

The report found that patients aged 65 and older had the most avoidable instances of admissions. “Potentially preventable hospitalizations—inpatient stays that might be avoided with the delivery of high-quality outpatient treatment and disease management—serve as useful indicators of possible unmet community health needs,” say the report’s authors, Elizabeth Stranges and Carol Stocks of AHRQ.

The report found that rural hospitals had nearly double the rate of preventable admissions among patients with acute conditions than urban hospitals (7% of rural stays versus 3.4% of urban hospital stays). Potentially preventable chronic conditions accounted for 9.2% of stays in urban hospitals but 15.9% in rural ones. People who live in low-income communities were more likely to be admitted for a preventable condition than people who live in wealthier communities. Males were more likely than females to be hospitalized for a chronic preventable condition, but women were more likely to be hospitalized for a potentially preventable acute care condition. Nearly one in 10 admissions of uninsured people were for potentially preventable conditions, compared to 5.4% of admissions for people with private insurance or Medicare coverage.

The report comes from the Healthcare Cost and Utilization Project, a federal database that includes statistics from the

Nationwide Inpatient Sample, which includes hospital inpatient stay information. It represents non-federal, non-rehabilitation hospitals in 44 states.

Source: HealthLeaders Media, November 4, 2010, online (www.healthleadersmedia.com).

Social health support groups suspect

Researchers at Harvard University and Brigham and Women’s Hospital are raising questions about the accuracy of health information on social media.

The researchers, who examined the 15 largest Facebook communities dedicated to diabetes, found “tentative support” for the health benefits of social media in the management of chronic disease—evidence of patients sharing insights into their conditions not typically available through traditional medical channels. There was also evidence of community-building where emotional support is abundant. However, one in four comments on these sites were promotional in nature, generally for non-FDA-approved products, raising important concerns about the authenticity of participants on Facebook networking sites dedicated to diabetes. The researchers also identified numerous incidences of surveys, marketing pitches, and efforts to recruit patients for clinical trials where the true identity of the poster could not be confirmed.

The results of the study, underwritten by CVS Caremark, were published online in the *Journal of General Internal Medicine*.

Source: CVS Caremark, November 2, 2010, online (www.cvscaremark.com).

Follow-up care aids depression

Relatively simple interventions such as follow-up phone conversations with care managers appear to help patients control chronic depression symptoms.

The depression interventions were introduced in five family care practices at the University of Michigan Health System. Specifically, 728 enrollees were compared to 78 control patients receiving usual care for 18 months. At the end of the study, 49.2% of 120 enrollees who completed 18-month assessments were in remission, compared to 27.3% in the control group who were in remission. The interventions were not telephone therapy, says Michael Klinkman, MD, a professor of family medicine at the University of Michigan Medical School and lead author of the study.

The key was to keep patients in treatment. With this care management approach, physicians can closely monitor whether a patient’s condition is worsening. In many cases, patients simply don’t follow up—in these instances, physicians take the initiative.

Source: HealthLeaders Media, November 1, 2010, online (www.healthleadersmedia.com).

Elderly women unnecessarily catheterized

ED personnel place unnecessary urinary catheters in nearly half of women aged 80 or older who present for care, according to a 12-week study from

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St. John Hospital and Medical Center in Detroit.

The report, published in the November 2010 *American Journal of Infection Control*, raises questions about whether elderly women are being unnecessarily exposed to risk of infection, a known hazard of urinary catheterization (UC). The authors, Mohamad G. Fakih, MD, and colleagues, added that “the majority of U.S. hospitals do not have a formal system to monitor UC (urinary catheterization) utilization, and a significant proportion of patients discharged from the hospital to extended-care facilities may have an indwelling UC without a clear indication.” The federal government stopped reimbursing hospitals for such infections in Medicare patients two years ago, another reason why attention should be focused on this issue, the authors wrote. The researchers examined 532 instances of catheter placement and found that 48.3% (or 58) of those patients who were female and aged 80 or older did not have indications for catheter placement.

Source: *HealthLeaders Media*, November 2, 2010, online (www.healthleadersmedia.com).

New York health department funding EMR project

The New York Department of Health and public-private partnership New York eHealth Collaborative have released plans to create the country’s largest network for EMRs. The plans, submitted to the Office of the National Coordinator for Health

Information Technology, will spend \$129 million in state and federal funds to build and implement a statewide medical records network that will serve hundreds of hospitals, thousands of medical practitioners, and up to 20 million patients per year.

Once completed, New York doctors anywhere in the state will have instant access to critical medical records of every patient, eliminating the confusion and time consumption that often accompanies the sharing of medical records between healthcare providers. The proposed statewide network will link together several existing regional EMR networks with new infrastructure and programming, and state agencies will set policies to govern the system’s implementation and maintenance.

Source: *New York eHealth Collaborative*, October 26, 2010, online (www.nyehealth.org).

HealthGrades study ranks hospitals

Patients at five-star-rated hospitals had a 72% lower risk of dying when compared with patients at one-star-rated hospitals, according to a study by HealthGrades® of patient outcomes at America’s hospitals. According to the study, if all hospitals performed at the level of five-star-rated hospitals over the three years studied, 232,442 Medicare lives could potentially have been saved.

The *Thirteenth Annual HealthGrades Hospital Quality in America* study analyzed objective mortality and complication rates at all of the nation’s 5,000 nonfederal hospitals using 40 million hospitalization records obtained from

CMS. The study identified national and state-level trends in hospital care quality and established quality ratings for each hospital across 26 different procedures and diagnoses. Looking at overall trends, the HealthGrades study found that hospital mortality rates, on average, have declined by 7.98% from 2007 to 2009. Of the 17 mortality-based diagnoses and procedures analyzed, only two bucked the overall trend with increasing mortality rates: gastrointestinal surgeries and coronary intervention procedures.

As part of the study, HealthGrades rated individual hospitals with a one-star, three-star, or five-star rating in each of the 26 procedures and diagnoses. A one-star rating means that the hospital performed below average, to a statistically significant degree, when compared with the other 5,000 hospitals. A three-star rating means the hospital’s performance was average, and a five-star rating means the hospital outperformed the national average to a statistically significant degree.

Source: *HealthGrades*, October 20, 2010, online (www.healthgrades.com).

Hospital pay in line with economy

The quarterly costs to hospitals for growth in wages, salaries, and total compensation has steadily declined over the past decade and now is roughly the same as the wage, salary, and total compensation growth for all workers in the overall economy, according to data from the U.S. Bureau of Labor Statistics (BLS).

In the fourth quarter of 2001, BLS data show that the cost increases to

hospitals for wages and salary growth were 5.7% higher than they were in the fourth quarter of 2000. The cost of wages and salaries for all workers in the larger economy was 3.7% higher in the fourth quarter of 2001 than it was in the fourth quarter of 2000. Since the fourth quarter of 2001, however, hospitals and the larger economy have seen the cost of growth in wages, salary, and total compensation decline steadily. In the first three quarters of 2010, hospital wage and salary costs grew about 1.6% when compared with the first three quarters in 2009, while wages and salary costs for all workers increased about 1.5% for the same period. The growth in total compensation for hospital workers and all workers—which includes wages, salaries, health insurance, pension plans, 401(k) matches, and other perks—has followed a similar downward trend since the fourth quarter of 2001, according to BLS data.

Total compensation for employees cost hospitals 6% more in the fourth quarter of 2001 than it did in the

fourth quarter of 2000, while total compensation costs for all workers in the larger economy was 4.2% higher in 2001, according to the BLS. During the first three quarters of 2010, however, the growth of hospitals' total compensation costs for employees had slowed to 2.1% when compared with the first three quarters of 2009 and about 1.8% for all workers for the same three quarters.

Source: HealthLeaders Media, November 2, 2010, online (www.healthleadersmedia.com).

GSK pays \$750M Medicaid fraud

SB Pharmco Puerto Rico, Inc., a subsidiary of GlaxoSmithKline, PLC (GSK), has agreed to plead guilty to charges relating to the manufacture and distribution of certain adulterated drugs made at GSK's now-closed Cidra, Puerto Rico, manufacturing facility, the U.S. Department of Justice said. The resolution includes a criminal fine and forfeiture totaling \$150 million and a civil settlement under the False Claims

Act and related state claims for \$600 million.

The drugs, manufactured at the plant between 2001 and 2005, are Kytril® (a sterile anti-nausea medication), Bactroban (a topical anti-infection ointment commonly used to treat skin infections), Paxil® CR (the controlled-release formulation of the popular antidepressant Paxil), and Avandamet® (a combination Type II diabetes drug). The Food, Drug and Cosmetic Act (FDCA) prohibits the introduction or delivery for introduction into interstate commerce of any drug that is adulterated. The criminal information filed alleges that SB Pharmco's manufacturing operations failed to ensure that Kytril and Bactroban finished products were free of contamination from microorganisms. The criminal information further alleges that SB Pharmco's manufacturing process caused Paxil CR two-layer tablets to split. The splitting, which the company itself called a "critical defect," caused the potential distribution of tablets that did not have

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any therapeutic effect and tablets that did not contain any controlled release mechanism. The criminal information also alleges that Avandamet tablets manufactured by SB Pharmco did not always have the FDA-approved mix of active ingredients, thus potentially containing too much or too little of the ingredient with the therapeutic effect. Finally, the criminal information alleges that SB Pharmco's Cidra facility suffered from long-standing problems of product mix-ups, which caused tablets of one drug type and strength to be commingled with tablets of another drug type and/or strength in the same bottle.

SB Pharmco has agreed to plead guilty to a criminal felony for releasing into interstate commerce adulterated Kytril, Bactroban, Paxil CR, and Avandamet, in violation of the FDCA. Under the

plea agreement, the company will pay a criminal fine of \$150 million, which includes forfeiting assets of \$10 million. The guilty plea and sentence is not final until accepted by the U.S. District Court in Boston.

Source: U.S. Department of Justice, October 26, 2010, online (www.justice.gov).

Christ Hospital finalizes settlement

The Christ Hospital (TCH), which agreed in May to pay \$108 million to resolve a whistleblower lawsuit alleging illegal kickbacks, signed a corporate integrity agreement with the federal government that allows the Ohio hospital to continue to participate in Medicare and other federal healthcare programs.

Daniel R. Levinson, Inspector General at the U.S. Department of Health and Human Services, said in a statement that the agreement resolves an investigation dating back more than a decade. "This administrative case was resolved after the Office of Inspector General [OIG] met directly with TCH's board of trustees. OIG has maintained throughout negotiations with TCH that independent monitoring was needed to oversee the hospital's compliance with Federal healthcare

program requirements," Levinson said in a media release. "Once TCH's board of trustees met with OIG, we were able to successfully negotiate a [corporate integrity agreement] and close the door on this multiyear investigation."

TCH was told in May that OIG was considering excluding the hospital because it rewarded cardiologists for referring patients to TCH, a violation of the anti-kickback statute. TCH and The Health Alliance for Greater Cincinnati paid \$108 million to resolve False Claims Act liability for the conduct. Under the five-year corporate integrity agreement, TCH must implement compliance measures, hire an outside reviewer of its financial relationships with physicians, and be monitored by OIG. The agreement requires the trustees to annually review the hospital's compliance program and certify its effectiveness.

The government alleged that TCH, a 555-bed acute care hospital limited work at the Heart Station—an outpatient cardiology testing unit that provides noninvasive heart procedures—to cardiologists who referred patients to the hospital.

Source: HealthLeaders Media, October 29, 2010, online (www.healthleadersmedia.com). ■

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