Executive Resources, LLC

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Executive Resources, LLC ("EXEC")

Health Care Issues

Inside this issue:

Many healthcare providers are continuing to experience compression in their bottom lines as a result of reduced funding from Federal and State programs and loss of patient volumes. These pressures are exacerbated by an upward spiral of cost pressures such as wages, technological changes, pharmaceuticals, etc., leading to performance issues. Today's healthcare providers must seek alternative ways of providing access to quality healthcare for their constituents, while concurrently, maintaining their own financial viability. A STRATEGY that some institutions have employed in meeting their goals is the evaluation and elimination of low-margin services. These STRATEGIES have helped providers to continue to fulfill their community mission statement, as well as, reduce their deficits.

Federally Qualified Health Center Development

The Federally Qualified Health Center (FQHC) program is a strategy that can be employed to reduce costs. The FQHC program continues to make strides through ongoing Federal funding, whereas other Federal governmental programs have experienced funding reductions. For Federal FY 2007, both Houses of Congress passed Continuing Resolutions and the President signed a bill into law that boosts Community Health Center (CHC/FQHC) funding by $207 million. As a result, the total FY 2007 CHC budget equals $2 billion, supporting the final year of the President's Health Centers Initiative by increasing access to primary health care in 1,200 of the neediest counties across the nation.

The Health Resources and Services Administration (HRSA) is the principal Federal agency charged with increasing access to care, predominantly for medically underserved populations.

The President's FY 2008 budget calls for continued funding for FQHCs through a second expansion initiative to put a health center into every poor county in the nation that does not have one today. These developments are extremely important to hospitals that have been subsidizing their outpatient departments. This has created the impetus for many hospitals to redefine what health care business lines they should be in and whether primary care is one of them.

In New Jersey, Governor Corzine issued Executive Order No. 29 in October 2006 on **Rationalizing Heath Care Resources.** This executive order supports the development of FQHCs for financially distressed hospitals and creates a Commission, of which one task is to "Evaluate appropriate alternative uses to which such facilities might be put, including but not limited to, their redeployment as FQHCs...". Hospitals that are interested in exploring outpatient alternatives are increasingly willing to consider outpatient conversions and other unique relationships with existing FQHCs. Some of the major reasons for considering a conversion are, but are:

- Reduced ongoing outpatient subsidies
- Poor payor mix/inadequate payment rates
- Enhanced payment rates in FQHC setting
- Increased primary care access/alleviate primary care in the ER
- Potential for primary care provider malpractice coverage cost savings

FQHC development may not be right for every hospital, but structured properly, it can be positive for the hospital, for an existing FQHC, and for the community. Concurrently, it can enhance bottom-line financial viability of the hospital and create positive community support. Hospitals exploring outpatient alternatives for their organizations, can consider FQHC, FQHC Look-Alike, and Scope of Project Policy change with an existing FQHC, along with other alternatives, i.e. remaining status quo, closure.

Form 990 Update

June of this year is when we can expect a new Form 990 from the IRS. Slightly more pages and more questions, specifically relative to executive compensation, joint ventures and related parties, employment tax, fund raising, etc. is what should be anticipated. Executive compensation remains a hot topic, especially relative to IRS audits of tax-exempt hospitals and other non-profit organizations and even more specifically relative to routine examinations, indicating that the Federal government continues to look at areas of potential excessive compensation arrangements. A report issued in March by the IRS Exempt Organizations Office Technical Guidance and Quality Assurance Group delineated that significant errors and omissions by tax-exempt organizations, including hospitals exist relative to excess benefit transactions. The report has resulted in a large amount of amended 990s and collection of more than $21 million in excise taxes, including $4 million from non-profit health care organizations.

Have You Performed a Medical Staff Satisfaction Survey Recently?

Decreasing federal and State Medicaid and Medicare payment rates for both physicians and hospitals, the need to attract primary care, subspecialty care, and surgical physicians, and increasing competition all are paramount in the need for a hospital to conduct a Medical Staff Satisfaction Survey. Deploying a satisfaction survey is a cost-effective STRATEGY that hospitals can use to assess their Medical Staff's attitudes, desires, and concerns relative to the hospitals policies, services, and operations.

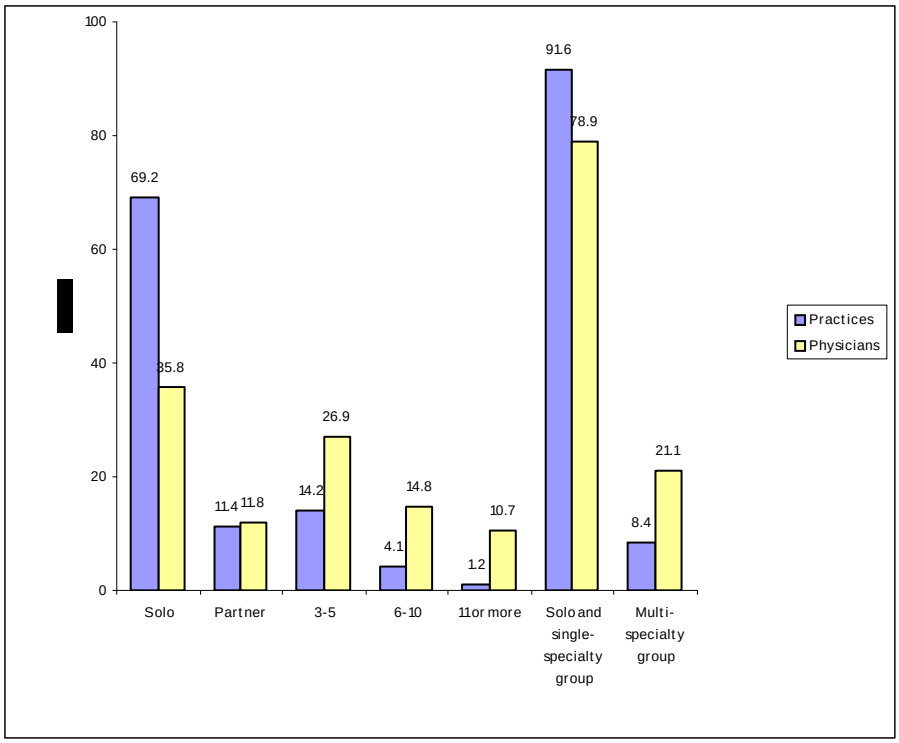
Hospitals that conduct Medical Staff Satisfaction Surveys do so in order to: 1) Measure physician attitude in various hospital operational areas, 2) Improve physician recruitment and retention, 3) Gauge interest on new programs and services, 4) Focus on areas of improvement, and 5) Obtain feedback from which actions can be taken at a cost-effective price. Hospital are committed to maintaining a high level of satisfaction among their medical staff, as well as a high level of communication and exchange of ideas in order to sustain an environment where issues and concerns are addressed in a satisfactory and timely manner.

Surveys should be performed in a confidential manner and serve as an effective tool to provide an effective, objective, and systematic process for assessing physician attitudes and concerns with the operations of the hospital. If utilized properly, these surveys can be a useful method to assess a variety of issues and monitor organizational performance.

The survey questionnaire should be developed that will be representative of the entire Medical Staff, and one that can be completed in no more than 15 minutes to encourage maximum participation. It is important that a hospital design an effective survey instrument that can be easily quantified with objective information. **Please call EXEC at 800-925-1919 for further details.**

Office-Based Medical Practices Update

In a March 2007 CDC report on physician practices entitled Office-based Medical Practices: Methods and Estimates from the National Ambulatory Care Survey, during 2003–04, there were, on average, 161,200 office-based medical practices in the U.S. involving 311,200 physicians or an average of about 2 physicians per practice. Although 35.8% of all office-based physicians were in solo practice, 69.2% of medical practices consisted of solo practitioners. The percentage of practices that are multi-specialty groups (8.4%) is smaller than the percentage of physicians in these practices (21.1%), although the percentage of practices that are in solo and single specialty groups (91.6%) is larger than comparable percentage of physicians in these practices (78.9%). The percent distribution of office visits by practice size more closely resembles the distribution of physicians than it does medical practices. Practices involving 11 or more physicians constituted only 1.2% of practices, but 9.8% of all visits occurred at these practices, since 10.7% of all physicians are employed there. In contrast, solo physician practitioners, who constituted 69.2% of all practices but 35.8% of all physicians, had 36.8% of all office-based visits. Similarly, solo and single-specialty practices and multi-specialty group practices constituted 91.6 and 8.4% of all practices, respectively, and 78.9 and 21.1% of all physicians worked in these practices, respectively. About 79.4 and 20.6% of all visits, respectively, were to solo and single-specialty practices and multi-specialty group practices. On average, medical practices received 45.1% of revenues from private insurance, 36.3% from Medicare, and 17.1% from Medicaid.



Importance of Physician (Community) Needs Assessments to Hospitals

Increasingly in an era where the OIG and the IRS have taken an increased proactive role in reviewing operations, terms, such as, Stark, anti-kickback and self-referral are as commonplace in the healthcare industry as laboratory, radiology, and surgery. Hospitals are best-advised to consider updating their Physician (Community) Needs when considering physician recruitment and programs remuneration along with financial incentives. The STRATEGIC objective of performing a needs assessment is to provide objective evidence of the need for the services of the recruited physician in the community or service area for which he/she is to serve along with appropriate support documentation. If your hospital has not updated its assessment or its Strategic Plan relative to physician need on an annual basis, it could be subject to Federal scrutiny when recruiting physicians.

OIG, Stark, IRS – It certainly looks like the health care industry has the federal government continually looking over its shoulder. EXEC has seen hospitals recruiting physicians in various specialties without the benefit of an appropriate physician (community) needs assessment due diligence. In recruiting physicians a hospital must demonstrate that a need exists in the service area that a physician is being recruited. The objective of a ***Physician Needs Assessment*** is to provide objective evidence of the need for the services of the recruited physician in the community for which he/she is to serve along with prepared contemporaneous documentation.

If a hospital has not prepared performed a Medical Staff Development Plan in the last year or at minimum, an update of the Plan, EXEC recommends performing a ***Physician Needs Assessment*** for the physician specialty that a hospital plans to recruit. Demonstrating physician need is in many cases, "ratio-driven" predicated on physician-to-population or patient visit ratios, some of which are outdated, such as, Graduate Medical Education National Advisory Council-GMENAC and Medical Economics, but which are still referred to by the Federal government.

Physician Needs Assessments should be taken to a level beyond ratio-driven reports, specific to physician subspecialty and surgery areas where there is limited physician need information available, i.e. interventional cardiology. The traditional ratio-driven methodology of demonstrating physician need, which is the cornerstone of medical staff development, must be modified or replaced in favor of other physician need contemporaneous documentation that will provide the necessary objective evidence as the rationale for recruiting a physician.

Besides physician-to-population or patient visit ratios, a hospital should look at changing service area demographics, physician demographics, health indicators, and utilization. EXEC recommends developing service utilization projections in accordance with accepted industry standards. For example, there is limited information available regarding specific Interventional Cardiology population-to-physician ratios (i.e. GMENAC, Medical Economics, Hicks & Glenn). Cardiology has standard population-to-physician ratios, whereas Interventional Cardiology is generally included in the broad category of Cardiology and sometimes categorized under medicine or surgical specialties. As a result, to develop the need for subspecialists such as an Interventional Cardiologist, the traditional physician need documentation must be modified or replaced. ***Physician Need Assessments*** should incorporate the following:

Why Your Hospital Should Perform a Physician Needs Assessment

- Service area population analysis – current, future (i.e. total, age-specific)
- Federal designation analysis – HPSA
- Population- and visit-based ratio analysis
- Provider inventory development – multiple offices, full time equivalency
- Physician unmet need/surplus need determination based on ratio analyses
- Health care incidence (i.e. morbidity, mortality, use rates, hospital discharge data) analysis
- Subspecialty practice analysis (i.e. revenue, fees, compensation, utilization/volume)
- Legal counsel opinion and analysis

The objective of a Physician Needs Assessment for health care recruiting entities is to provide the need for the qualified physician in the Service Area through contemporaneous evidence.

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Staffing, Capacity, and Ambulance Diversion Impact on ED Utilization

In a Centers for Disease Control (CDC) 2006 report on emergency room utilization entitled "Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States, 2003-2004," between 40 and 50% of U.S. hospitals experience crowded conditions in the emergency department (ED) with almost two-thirds of metropolitan EDs experiencing crowding at times. The report contains a number of findings, including:

- An average of 4,500 EDs were in operation in the United States during 2003 and 2004.
- Crowding in metropolitan EDs was associated with a higher percentage of nursing vacancies, higher patient volume, and longer patient waiting and treatment durations.
- Over half the EDs saw fewer than 20,000 patients annually, but 1 out of 10 had an annual visit volume of more than 50,000 patients.
- Most EDs used outside contractors to provide physicians (64.7%).
- Half of EDs in metropolitan areas had more than 5% of their nursing positions vacant.
- Approximately one-third of U.S. hospitals reported having to divert an ambulance to another emergency department due to overcrowding or staffing shortages at their ED.

This report provides many basic statistics necessary for reviewing the structure, process, and patient profile characteristics associated with the delivery of emergency medical care in this country. It also provides national benchmarks for potential measures of workflow necessary for understanding, monitoring, and managing ED crowding. Selected ED indicators delineated from the report relative to staffing, capacity, ambulance diversion, and throughput indexes are presented in the following figure.

Index	Total	Metropolitan	Not Metropolitan
Daily visit volume	67.6	93.4	25.8
Standard treatment spaces	14.6	19.8	6.3
# of physicians with ED privil.	13.3	17.5	6.4
Daily visits per treatment space	4.6	4.9	4.1
% of nursing positions vacant	5.3	6.1	3.9
% arriving by ambulance	13.0	13.8	11.8
Avg. waiting time in minutes	37.1	45.8	22.8
Avg. visit duration in minutes	159.7	181.6	124.2
% left before seen	1.4	1.8	0.7
% transferred	3.0	2.1	4.5
% admitted to hospital	12.5	13.4	11.1
Inpatient staffed bed size	136.5	192.1	47.7
Inpatient daily occupancy rate	60.3	66.4	50.6
Annual hrs.on ambulance diversion	146.0	242.7	0.5