Nightingale's Healthcare News

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inside

Will Reform Really Happen This Time?

Healthcare Executives Take Out Their Crystal Balls

by Lisa Jaffe Hubbell

It happened once before, in 1992, when there seemed to be an impetus to change the healthcare system as a new president came into office. We all know how that worked out. Once again, a new regime is in power, and healthcare change is high on the agenda. But will it really happen? *Nightingale's Healthcare News* asked a variety of healthcare organizations what they think the advent of the Obama administration means – to their specific organizations, as well as to the healthcare industry in general. This month, we look at some of their responses about their hopes for change. Next month, we'll look at their opinions on how the recession will impact any potential change.

Tom Epstein, Vice President of Public Affairs at Blue Shield of California has a unique

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Credit Crunch Hitting Hospitals Hard

Construction Projects Halted Everywhere

by Steve Raphael

The nation's credit crunch is taking a huge toll on America's nonprofit hospitals. For-profit hospitals are faring little better.

According to a national survey of 736 hospitals released in November by the American Hospital Association (AHA), hospital executives say they are experiencing tight credit, higher borrowing costs, and investment losses. The total average hospital profit margin for the third quarter of 2008 was negative 1.6 percent, compared to 6.1 in the third quarter of 2007. Operating margins for the third quarter 2008 were 2.9 percent, compared to 3.9 percent in the third quarter 2007, the AHA says.

Regarding hospital financial viability, "There is a significant level of concern," says

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RFID Reaches Tipping Point in Healthcare

Resistance to Some Uses, But More Hospitals Adopt

by Lisa Jaffe Hubbell

Check out the many recent scholarly articles on healthcare applications for radio frequency identification sensors (RFID) and one can understand why Jason Howe, CEO of RFID company Awarepoint, thinks that just about every major healthcare organization in the country soon will be using active RFID to track medications and equipment, for safety and security of certain patient populations, and to study workflow among staff and patients.

"It's past its infancy, but not yet extensive," says Howe. Right now, about 10% of healthcare organizations use some sort of active RFID technology. Passive technology – where something is tagged and a power source reads the tag – is more ubiquitous. Active technology includes tags with a power source that every three to five seconds lets the system

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perspective on what's going on in Washington, DC: he served as a Special Assistant for Political Affairs in the Clinton White House where he was involved in Hillary Clinton's attempts to change healthcare and worked under Rahm Emmanuel during that administration. He's optimistic about the potential for change, but doesn't think it will happen as fast as some want. In the medium term, he thinks that something like the Massachusetts system of shared responsibility will be proposed and probably go through. "I think that Obama and the Congress are committed to this, and I think we have learned the lessons of the Clinton failure," he says. "The problems are worse now, and a larger number of constituencies believe change is needed." He noted that a lot of large payers that vocally opposed the 1992 efforts at reform are behind change this time. "I think they understand that they will have to trade profit margin for volume and ensure that most of the people who are not covered now will be covered in the future." This will all have to happen in the next couple of years or the impetus for change will die out, he says. "I think there is real consensus and will there; but there are a lot of things going on in the world now, and they may intervene to delay or defeat health reform."

John Baackes, President of Senior Whole Health, a health plan for the elderly poor in the Northeast, thinks that not much will look different in four years. "We are in the government programs business and cater to age-related dual eligible populations, and their numbers are growing. We won't have a shortage of business," Baackes says. There will be a lot of talk in the coming years about coordinating care and management programs for the highest risk patients. He says there will probably be changes to Medicare Advantage programs, but most of the changes that people will see after an Obama term will be modest. "We are talking about recreating models this time, not creating a single payer system. The current system will be extended, not done away with. How healthcare is delivered just won't change that much."

The biggest issue Baackes sees is a problem finding enough primary care physicians to take care of the increased number of patients that will have coverage. "I hope they will create some incentive to get more physicians to choose primary care. But that may not happen during the first round of reforms."

The difference between 1992 and now is that Obama is approaching healthcare reform in a "much more realistic manner," says Susan Berson, a lawyer at Mintz Levin's healthcare practice in Washington, DC. "In 1992, they gathered a team, wrote a thousand pages of reform, and asked Congress to pass it. There was no buy-in. Obama will work with Congress," she says. And while the loss of Tom Daschle at the helm of Health and Human Services may affect how well and how fast reform gets to and through Congress, it will happen. "A lot of the initiatives just aren't controversial, like more health information technology, and steps to bring insurance to more of the uninsured and unemployed." Another change: more emphasis on disease management and preventive care. "This is a real change from the last eight years when there has been no federal support of healthcare. The new guy is really into funding research, preventive care, and technology. I really believe we will see change this time."

"We have a great opportunity going forward," says George DeVries, Chairman of American Specialty Health, a company that focuses on patient wellness programs. "They were talking 10 years ago about disease management, but now employers and health plans are talking about health and want to stop waiting for people to get sick, but rather take care of people who are at risk." DeVries hopes

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Caroline Steinberg, AHA Vice President for Trends Analysis. "We are certainly facing unprecedented economic conditions, and how this will play out in the hospital field depends on how long and how deep this economic slowdown is."

Hospital executives polled in the AHA survey said the credit crunch is making it difficult and expensive for hospitals to finance new facilities and purchase new equipment. Philanthropy is also down.

Many hospitals were already struggling before it became more difficult to obtain capital. Uninsured patients and charity care remain long-term health care issues "that are exacerbated during a recession," says John Cline, Vice President of Rating Communications for Moody's Investor Services. Moody's found that operating margins for nonprofit hospitals in the third quarter last year were 2.9 percent, compared to 3.9 percent for the third quarter in 2007.

In the first two months of the fourth quarter 2008, Moody's downgraded 18 hospitals and upgraded one, the worst spike in downgrades in more than a decade.

It is not a "sampling," Cline cautions. "The downgrades are particular to those hospitals. It's hard to gauge performance because the recession is still unfolding."

The outlook for for-profit hospitals is slightly better. With more cash on hand, better access to equity and debt capital, and more latitude to trim costs and capital expenditures, Moody's believes for-profit hospitals can weather the storm better than nonprofits.

The practical effects of the credit crisis is being demonstrated around the country. Hospitals big and small, nonprofit and for profit, urban and rural, are retrenching. Royal Oak, MI-based Beaumont Hospitals, traditionally one of the state's most vigorous hospital systems, is facing a $60-million shortfall and is postponing a big cancer radiation center, freezing jobs, and asking executives to take pay cuts. It continues to go forward with building a new medical school with Oakland University in nearby Rochester.

"What we're seeing in southeast Michigan is being played out all across the state," says David Seaman, Executive Vice President of the Michigan Health & Hospital Association. Seaman attributed hospital cutbacks to under-reimbursement and losses related to serving the uninsured and Medicare and Medicaid patients. Survival isn't threatened, though many new projects have been put on hold, he adds.

Some major hospital construction projects continue in Michigan. Henry Ford Health System's $300-million West Bloomfield Hospital will open in the spring, while a $523-million University of Michigan children's and women's hospital in Ann Arbor and a $250-million children's hospital at Spectrum Health in Grand Rapids remain on schedule.

In rapidly growing Porter County in northwest Indiana, the economy has forced three hospitals systems – Community Healthcare System of Munster; Mishawaka-based Sisters of St. Francis Health Services; and Indiana's largest hospital system, Clarian Health of Indianapolis – to put hospital construction plans on hold. Memorial Hospital and Health System of South Bend has delayed construction of a 100-bed hospital in Valparaiso, originally slated for completion in 2011.

Franklin, TN-based Community Health Systems, the nation's largest hospital chain says a strong third quarter will allow it to replace a 70-year-old Valparaiso hospital it bought in 2007.

Citing a failure to secure bond financing for Penn State University's Milton S. Hershey Medical Center the university is

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Research Report

Who's Who in Teva Pharmaceutical Industries Ltd. and Barr Pharmaceuticals, Inc.

by Francoise C. Arsenault

Teva Pharmaceutical Industries Ltd. (Teva) is a global pharmaceutical company specializing in the development, production, and marketing of generic and proprietary branded pharmaceuticals and active pharmaceutical ingredients (APIs) in North America, Europe, Latin America, Asia, and Israel. The company offers generic pharmaceutical products in various dosage forms, including tablets, capsules, ointments, creams, liquids, injectables, and inhalants. Teva is among the top 20 pharmaceutical companies and among the largest generic pharmaceutical companies in the world.

The principal products of Teva include Copaxone for multiple sclerosis and Azilect for Parkinson's disease. The company also provides specialty pharmaceutical products and branded respiratory products. In addition, the company offers APIs for respiratory products, dermatological hormones, anti-inflammatories, oncolytics, immunosuppressants, and muscle relaxants, as well as custom-manufactured APIs for various proprietary drug manufacturers. Teva, which was founded in 1901, is headquartered in Petach Tikva, Israel. Eighty percent of Teva's sales, which totaled $9.4 billion in 2007, are in North America and Europe. Teva has more than 28,000 employees and production facilities in Israel, North America, Europe, and Latin America.

Barr Pharmaceuticals, Inc. (Barr) is a Delaware holding company whose principal subsidiaries, Barr Laboratories, Inc. and Duramed Pharmaceuticals, Inc., develop, manufacture, and market generic and proprietary pharmaceutical products. The company's generic products are marketed under the "Barr" label and proprietary products are marketed under the "Duramed" label. In the generic pharmaceutical segment, Barr manufactures and distributes approximately 150 different dosage forms and strengths of about 75 generic pharmaceutical products. In the proprietary pharmaceutical segment, Barr manufactures and distributes 19 proprietary pharmaceutical products, largely concentrated in the female healthcare arena.

Barr operates manufacturing, research and development, and administrative facilities in eight locations in the United States. The company's headquarters are in Montvale, New Jersey. Founded in 1970 in New York as Barr Laboratories, Inc., Barr was among the first generic pharmaceutical manufacturers in the United States. During the past decade, Barr has expanded through internal development, as well as strategic acquisitions. The largest of these acquisitions were Duramed in 2001 and PLIVA in 2006. In 2007, Barr had sales of approximately $2.5 billion and about 9,000 employees.

On December 23, 2008, Teva completed the $7.5 billion acquisition of Barr. Each share of Barr common stock was converted into the right to receive $39.90 in cash and 0.6272 Teva American shares. Teva also assumed $1.5 billion of Barr's debt. The transaction, announced on July 18, 2008, created a combined company with a significant presence in more than 60 countries and approximately $13.6 billion in revenues on a pro-forma basis for the 12 months ended September 30, 2008. With the close of the acquisition, Barr became a wholly owned subsidiary of Teva.

Transaction Professionals

Eli Hurvitz is the Chairman of the Board of Directors of Teva Pharmaceutical Industries. **Shlomo Yanai** is the President and Chief Executive Officer. **Eyal Desheh** is the Chief Financial Officer. **Rodney Kasan** is Vice President and the Chief Technology Officer. **William S. March** is the President and Chief Executive Officer of Teva North America. **Uzi Karniel** is the General Counsel and Corporate Secretary.

Bruce L. Downey is Chairman of the Board and Chief Executive Officer of Barr Pharmaceuticals. **Jane F. Greenman** is Executive Vice President, Global Human Resources. **Carol A. Cox** is Senior Vice President, Global Investor Relations and Corporate Communications. **Frederick J. Killion** is Executive Vice President and General Counsel. **William T. (Bill) McKee** is Executive Vice President, the Chief Financial Officer, and Treasurer.

Willkie Farr & Gallagher LLP served as external legal counsel to Teva. The transaction was handled by Partners **Peter H. Jakes**, **Jeffrey S. Hochman**, **David E. Rubinsky**, **Christopher J. Peters**, **William H. Rooney**, **Jochen Winter**, **Jacques-Phillippe Gunther**, and **David Tayar**; national partner **Stefan Joergens**; special counsel **David K. Park** and **Jonathan J. Konoff**; and associates **A. Mark Getachew**, **Manuel A. Miranda**, **Daniel Backer**, **Jordan A. Messinger**, **Katie M. Calabrese**, **Rebecca H. Gutner**, **Curtis W. Hogan**, **James Crowe**, **Jeffrey Korn**, **Melanie Butcher**, **Theodore A. Neos**, **Amy R. Fitzpatrick**, **Christopher J. Williamson**, **Kristin Marie McNamara**, and **Alejandro Rosenberg**.

The law firm of **Tulchinsky Stern Marciano Ben-Zur Cohen & Co.** served as Israeli counsel to Teva on the acquisition. **Menachem Tulchinsky** and **Yaacov Michlin**, partners, led the team.

Goodwin Procter LLP provided Teva with legal counsel on intellectual property and product liability matters. **David M. Hashmall**, **Frederick H. Rein**, and **Jonathan I. Price**, partners, worked on the acquisition.

Kirkland & Ellis LLP provided Teva with advice on antitrust and Food and Drug Administration matters. **Jay P. Lefkowitz**, a partner in the firm's New York office, directed the work.

Simpson Thatcher & Bartlett LLP represented Barr in the transaction. The Simpson Thatcher team included **Gary I. Horowitz**, **Andrea K. Wahlquist**, **Gary B. Mandel**, and **David E. Vann, Jr.**, partners; **Adeeb R. Fadil**, senior counsel; and **Douglas E. Bacon**, **William M. Freiberg**, **Sean P. Murphy**, **Adam S. Booken**, **Wonda Joseph Quinn**, **Noah D. Beck**, **Jason R. Vollbracht**, **Ketan P. Jhaveri**, **Noah M. Leibowitz**, **Jacqueline M. Rosenblum**, and **Marcela Robledo**, associates.

Lehman Brothers Inc. acted as the banker and financial advisor to Teva on the deal. **Mark G. Shafir**, who was managing director and global head of Mergers and Acquisitions at Lehman Brothers, directed the work on the engagement. **Jason Fertig** and **Punit Mehta** also were part of the team.

Banc of America Securities LLC acted as the financial advisor to Barr for the transaction.

Paul D'Onofrio, **Matthew Miller**, **Chris Seiter**, and **Michael Brocka** worked on the engagement.

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that there will be more programs like his included in the changes that mandate wellness programs and help people avoid chronic illnesses like diabetes that are related to poor lifestyle choices.

Not everyone is as enthusiastic. John Shufeldt, MD, Founder and CEO of NextCare Urgent Care says, "I'll believe it when I see it when it comes to reform. Unless you have all the players at the table and all interests addressed it won't be solved. The challenge is that the money has to come from somewhere. Docs and institutions fear the money will come off their back. Emergency departments take whoever walks in the door – and happily – but at the end of the day, someone has to pay for it. It's a really nice thought that everyone will be covered, but I don't know."

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delaying construction of its new $235 million Penn State Hershey Children's Hospital, says CEO Harold Paz. Other construction is not affected, including a cancer institute and a second-floor expansion of the medical center

In Minnesota, market forces are the culprits for the University of Minnesota Medical Center delaying construction of a $200 million building for outpatient care. The five-story, 300,000-square feet Ambulatory Care Center is the biggest local medical-construction project so far to fall victim to the economy, although hospital officials say the center will be built.

Four of the Twin Cities' major hospital groups – Allina, Fairview, North Memorial, and Park Nicollet – have cut a total of more than 1,000 jobs in recent months because of the weak economy. And, in New Jersey, where 47 percent of hospitals lost money in 2007, 5 of the 79 acute-care hospitals closed in 2008, and a sixth may close soon. In Hawaii, two hospitals filed for bankruptcy and one nearly closed.

The AHA's Steinberg says these cutback situations are "spot trends," and whether the hospital closures continue will depend on the length and severity of the recession. Traditionally healthcare has been thought to be recession proof, but that may not be the case in this economy.

The healthcare needs of the public must still be met, however, even as the number of uninsured and underinsured continue to grow. "Hospitals can't lay off care givers and are now eyeing paring administrative costs and even shutting down complete services, such as home healthcare, behavior health, and burn units that "are expensive to maintain and serve a fewer number of patients," Steinberg says.

Steinberg sees one bright spot. The economic situation is heightening calls for reform, and President Obama has made healthcare reform one of his top priorities. ¤

RFID, *from page 1*

know it exists. Right now, Howe says technology has three- to five-year batteries for active systems. RFIDs are primarily used for asset tracking.

"Some healthcare campuses are enormous," he says. "Jackson Memorial Health System has millions of square feet in several buildings. If you have an infusion pump, you can immediately know where it is."

Infant tracking systems use a combination of active and passive technology. The Hugs system by VeriChip is an example – it will lock a sector down and sound an alarm if a chip passes a certain point, while also telling the system where the chip is in the building.

For medications, passive technology can allow providers to know where pharmaceuticals will go. Some medications can also have an active tracking system element, says Howe, to ensure that it goes to the right patient at the right time. Cardinal Health of Dublin, OH, has an RFID system that uses a passive bar code that alerts systems when medication expires. Awarepoint uses something similar with blood products to ensure that they are kept at the appropriate temperature and used within a certain time frame.

Tracking equipment is a no-brainer, Howe says. It can reduce shrinkage, rental, and replacement costs. Depending on the system, using RFID for that purpose alone will pay for itself in a matter of months.

While most people accept that asset tracking – medications, equipment, etc. – is a sure thing, there are some applications that people may not embrace as easily. Ken Foster, a professor at the University of Pennsylvania, published a recent study on the ethics of RFID use in implantable applications. "There is an unease about it," Foster says. Indeed, other studies have noted that while people seem fine with RFID tracking things, they aren't so excited about the technology being used to track people.

Howe says he's seen that concern play out when facilities want to do time and motion studies on staff using RFID tracking – even for a short period of time. "They see it as an element of big brother," he says. Physicians, nurses, and patients seem a lot more willing, particularly if they know they are part of a study that might help streamline the healthcare process in a given facility.

"That's not widely done yet," he says, noting that Vocera's communication badge system is one of the leaders in this kind of research.

Costs for the systems vary. Most will run into the hundreds of thousands of dollars. Awarepoint, charges $5-10 per asset per month. "That's soup to nuts – infrastructure, installation, reports, everything," Howe explains.

Even under other cost structures, though, it's a good deal, provided that five elements can be met, he says:

- First, the system should allow you to search through the entire facility, not just the OR, ER, or some other section.
- It needs to have room-level accuracy. A system that tells you an infusion pump is somewhere around a particular room isn't much help if you then have to look through several rooms to find it.
- Third, it should be minimally invasive. "Most will cable the institution, and it can be disruptive," Howe says. "We can do a million square feet in a week, and in the end, the system plugs into an outlet."
- Fourth, the system should be easy to use and interoperable with other systems.
- Lastly it should be easy to take out if you don't like it.

"Every healthcare organization will have to have this," Howe says, and while he is quick to tout his own company's expertise, there are other operators out there that do good work: AeroScout, Versus, and Radianse, among them.

The future looks even more interesting than what's out there now, Howe says. In the future, RFID technology will be tied to an electronic medical record. The technology will be able to improve quality by ensuring that patients get the right medication at the right time and equipment needed to deliver that medication is available and in the right place. It could also help to drastically reduce medication errors. "I think by 2012 that's what we'll be seeing," Howe says. They get closer every day: he recalls a recent event where an infusion pump delivered 10 times the dosage it was supposed to. Because of RFID tracking, the pump was quickly located, taken out of service, and repaired. "That's the future of this technology." ¤

Special Report

Major Healthcare Transactions – 2008

Acquiring Company	Acquired Company	Transaction Amount	Date Completed
The Blackstone Group	Aprial Healthcare Group	$1.7 billion	October 28, 2008
Inverness Medical Innovations	Matria Healthcare, Inc.	$1.18 billion	May 9, 2008
Vestar Capital Partners	Radiation Therapy Services	$1.1 billion	February 6, 2008
Amedysis, Inc.	TLC Health Care Services	$395 million	March 26, 2008
Senior Housing Properties Trust	37 properties from HRPT Properties Trust	$346.8 million	as of December 24, 2008
Banner Health	Sun Health	$316 million	September 2, 2008
Capella Healthcare	9 hospitals from Community Health System	$315 million	March 1, 2008
Emeritus Corporation	24 properties from Nationwide Health Properties	$305 million	April 3, 2008
Codgell Spencer, Inc.	Marshall Erdman & Associates	$247 million	March 10, 2008
Emeritus Corporation	19 properties from Healthcare REIT	$222.7 million	July 1, 2008
Medical Properties Trust	10 properties from HCP	$168 million	April 22, 2008
TowerBrook Capital Partners	majority interest in Broadlane	$160 million	August 19, 2008
Community Health System	Empire Health Services	$156 million	October 1, 2008
WaterStreet Healthcare Partners	69% interest in Care Centrix from Gentiva	$147 million	September 25, 2008
Medical Properties Trust	7 properties of HCP	$138 million	April 2, 2008
Loyola University Health System	Gottleib Memorial Hospital	$90 million	July 1, 2008
Emeritus Corporation	10 properties from Healthcare REIT	$77.2 million	October 20, 2008
Emeritus Corporation	5 properties of Ventas, Inc.	$62.5 million	December 19, 2008
Gentiva Health Services	Home Health Care Affiliates	$55 million	March 3, 2008
Good Samaritan Hospital	Dayton Heart Hospital	$55 million	March 18, 2008
NHP/McShane SAMC LLP	7 properties from St. Anthony's Medical Center	$50 million	January 25, 2008
Grubb & Ellis Healthcare REIT	5 properties from The Cirrus Group	$48 million	October 1, 2008
Almost Family, Inc.	Patient Care, Inc.	$46.5 million	August 1, 2008
Mountain States Health	Russell County Medical Center	$45 million	February 1, 2008
Daniel Corporation	HealthSouth Corporate Campus	$43.5 million	March 31, 2008

Source: Healthcare Prospector, published by the Beard Group

Worth Reading

Harvest Moon – Portrait of a Nursing Home

Author: Sallie Tisdale
Publisher: BeardBooks
Softcover: 218 pages
List Price: $34.95

Review by Henry Berry

Sallie Tisdale uses her vantage point as a registered nurse to present an intriguing look at the structure, operations, staff, and patients of a typical nursing home named Harvest Moon. The privacy of the people she encounters at work has been protected with pseudonyms, but her descriptions of physical facilities, the behavior of individual patients, the commitment of nurses, and other varied issues and relationships encountered in nursing homes will be recognized as true by anyone familiar with this area of healthcare.

Harvest Moon is, in the main, a humanistic portrait of a nursing home. Tisdale takes no political position, nor does she offer solutions to the problems of nursing homes and the larger social problem of providing quality healthcare for the elderly. In keeping with the book's humanistic tone, the author is also not critical of any of the many individuals who appear in her fictionalized, but true-to-life, nursing home.

Harvest Moon, like the large majority of nursing homes that have a limited number of patients, staff, and administrators and a singular focus on care for the elderly, adopts a kind of tribal village approach (rather than a corporate approach) to providing healthcare for the aged. Without going into the causes of problems in the nursing home industry, Tisdale does nonetheless note that the shift "undeniably and inexorably toward profit" in this field has created a situation where the "demands of profit-oriented budgets are made worse by the shortage of help." Staffing issues have long been a problem in an industry where the annual turnover rate is sixty percent. Although the "boom" of the nursing home industry has run its course since the book was first published in 1987, conditions in nursing homes are still more or less the same, and the same problems remain. The author's observations that the cost of nursing-home care sometimes causes "impoverishment" for individuals and their families is familiar.

With scenes, dialog, recurring characters, and a loose story line, the book reads like a novel. Tisdale's remark, "It is a beautiful and perfectly clear day, a day of short sleeves and no clouds," draws a sharp contrast with the atmosphere of the nursing home with its fluorescent lights that illuminate the same no matter what kind of day it is. A relative of one of the patients comes in with "a shiny pink raincoat." Her hair "falls lankly below her stooped shoulders" as she "steps up to the counter like a Fate." In another place, "smells of kitchen steam and urine, mop buckets and laundry, and disinfectant...mingle together in the halls." These and other vivid descriptions draw the reader into the experience of having entered a nursing home.

Unlike most other books that look into the healthcare industry, *Harvest Moon* does not delve into issues of organizational structure, present cost analyses, opine about government intervention, or offer a laundry list of solutions. Yet all of this can be plainly inferred by any reader with knowledge of the recognized problems of modern-day healthcare and the debates on dealing with those problems.

In places, Tisdale cites numbers and other facts of the nursing-home field – for example, "…there are almost 24,000 nursing homes in the United States….Nursing homes house two million people at a cost of over $30 billion dollars annually – about eight percent of all the dollars spent nationally on health care." In other places, she uses settings, situations, and individuals to bring in background material on the nursing home industry. Such techniques do not take away from the author's aim of conveying just what things are like in a nursing home – rather they supplement her objective. For example, her vivid description, "[t]he third hall, C Wing, is a sickly orange, and has room for forty patients requiring professional nursing, or 'skilled care'", is followed in the same paragraph with an explanation of what "skilled care" means and how it differs from the care provided in hospitals. She continues on to further explain how the skilled care of modern healthcare for "patients who would have never left the hospital" in previous decades but now must do so because of the crushing costs of hospital stays is part of the reason for the growth of nursing homes and the problems they try to deal with. But, as always, Tisdale returns to the illustrative examples of Harvest Moon. For example, a paragraph begins, "The patients on C Wing are notable most of all for variety in condition and disease," followed by the naming of these.

There is no better book than *Harvest Moon* for getting a true picture of a nursing home. It is an exemplary humanitarian tale, while also relating the fundamentals of the business and healthcare issues that have to be taken into account for problems with nursing homes to be alleviated and perhaps some day remedied.

A registered nurse, Sallie Tisdale is the well-known author of six books and many articles and also a contributing editor of the magazine Tricycle. *Her work and interests in the healthcare field have been recognized with awards and fellowships, including an NEA Fellowship.*

Special Report

Significant Healthcare Policy Analysts

Name	Affiliation	Activities
Paul Dennett Senior Vice President Health Care Reform	American Benefits Council Washington, DC Tel: (202) 289-6700 www.americanbenefitscouncil.org	Directs the Council's efforts on healthcare reform, including as it relates to the federal standards established by the Employee Retirement Income Security Act of 1974. The Council represents companies that either sponsor or administrator health and retirement benefits covering more than 100 million Americans.
Steve Findlay Healthcare Analyst	Consumers Union Washington, DC Tel: (202) 462-6262 www.consumersunion.org	Helps track and develop policy on a range of healthcare issues, with special focus on provider accountability, quality improvement, health information technology, the FDA, and prescription drugs. Previous work has focused on health insurance coverage, healthcare cost issues, and Medicare.
Bowen Garrett Senior Research Associate Health Policy Center	Urban Institute Washington, DC Tel: (202) 833-7200 www.urban.org	Leads the development of the Health Insurance Policy Simulation Model, a microsimulation model of health insurance reforms. Research focuses on employer-sponsored insurance, Medicaid and the uninsured, and Medicare's prospective payment systems.
Martin Gaynor Professor of Economics & Health Policy	Carnegie Mellon University Pittsburgh, PA Tel: (412) 268-7933 www.heinz.cmu.edu	Research focuses on competition in healthcare markets and role of incentive structures within the context of the current rapidly changing structure of healthcare markets, with implications for appropriate antitrust and regulatory policy.
Peter Jacobson Professor of Health Law & Policy School of Public Health	University of Michigan Ann Arbor, MI Tel: (734) 936-0978 www.sph.umich.edu	Current research focuses on relationship between law and healthcare delivery, law and public health systems, public health ethics, and healthcare safety net services. Also examining how public health practitioners define and resolve ethical challenges.
Michael R. Lardiere Director of Health Information Tech. Senior Advisor for Behavioral Health	National Association of Community Health Centers Bethesda, MD Tel: (301) 347-0400 www.nachc.com	Responsible for developing strategy and assisting health centers across the nation in implementing HIT strategies to improve quality care. Is engaged with health centers, health center controlled networks, primary care associations, RHIOs, and other systems to advance health information exchange.
Michelle Mello Professor of Law & Public Health Department of Health Policy & Management	Harvard School of Public Health Boston, MA Tel: (617) 432-0217 www.hsph.harvard.edu	Research includes studies of factors contributing to medical errors in the hospital, legal relationships between academic investigators and industry sponsors of clinical trials, administration of "no fault" system of compensating medical injuries, and ethical issues confronting the pharmaceutical industry.
Mark V. Pauly, Ph.D. Professor Health Care Management Department	Wharton School University of Pennsylvania Philadelphia, PA Tel: (215) 898-6861 www.wharton.upenn.edu	Specializes in medical economics and health policy. Current research involves analysis of health reform, conceptual foundations for cost-benefit analysis of drugs, the future of Medicare, health insurance design, and anomalies in insurance.
Judith A. Salerno, MD Chief Operating Officer & Executive Director	Institute of Medicine Washington, DC Tel: (202) 334-2352 www.iom.edu	Work centers on subjects ranging from quality of medical care to protecting the nation's food supply, with the objective of improving decisionmaking by identifying and combing relevant evidence to inform the deliberative process.
Vivian Wu Assistant Professor School of Policy, Planning & Development	University of Southern California Los Angeles, CA Tel: (213) 740-6526 www.usc.edu	Research includes the price bargaining between hospitals and health plans, hospital dynamic pricing between private and public payers, the effect of managed care and managed care backlash, and the market entry of Medicare Advantage plans.

In Focus

Group Health Cooperative

Group Health, a non-profit healthcare system based in Seattle, WA, has been a pioneer in healthcare delivery. In 1975, it was among the very first to create a computerized prescription drug system that gave doctors and pharmacists instant information about patients' drug histories, including allergies and potential interactions. It began issuing report cards on quality based national standard measures in 1992 – one of the first organizations to do so – and in 2005, Group Health implemented the first phase of a state-of-the-art clinical information system that supports both personal physicians and their patients in a number of ways, including computerized physician order entry functions for pharmacy and ambulatory care.

Group Health covers nearly 600,000 lives in Washington and Idaho through itself and its affiliates, Group Health Options and KPS Health Plans. Formed in 1947, the organization includes more than 9,000 staff members, including 1,500 nurses and about 900 physicians. Among the employers using its services are Microsoft, Boeing, Nordstrom, and Wells Fargo.

Group Health also has a research wing with more than 250 staff, Group Health Center for Health Studies that conducts clinical research, much of which is published in peer-reviewed journals in collaboration with strong research organizations such as the University of Washington and Fred Hutchison Cancer Research Centers. Its third wing, the Group Health Foundation, has an $11 million endowment that awarded more than $2 million in grants in 2007.

A little more than a decade ago, Group Health affiliated with Kaiser Permanente. Although they remain separate organizations, they work together in areas such as marketing, sharing best practices, and member reciprocity.

Group Health has long prided itself on maintaining high customer satisfaction and was named the best in terms of customer satisfaction in the Northwest in 2008. Among the national initiatives in which Group Health participates: The National Committee for Quality Assurance HEDIS report cards; the Institute of Medicine's recommendations for patient safety; the Hospital Quality Initiative; and the Institute for Healthcare Improvement's 100,000 Lives Campaign.

Group Health is governed by a consumer elected board of trustees that also has oversight duties. Its day to day operations are provided by the following executive leadership team:

- **Scott Armstrong**, President and Chief Executive, started with Group Health in 1986. He assumed the role of President in 2005. Before joining Group Health, he was Assistant Vice President of Hospital Operations at Miami Valley Hospital in Dayton, OH.
- **Michael Soman**, MD, is President and Chief Medical Executive for Group Health Permanente, and Executive Medical Director of the Group Practice Division. He took on the former role in July 2008. He joined the organization as a family doctor in 1984.
- **Brenda Bruns**, MD, is Executive Medical Director of the Health Plan Division, where she is in charge of optimizing care delivery. She has worked for more than two decades in a variety of hospital, health plan, and academic settings.
- **James Hereford** is Executive Vice President for Strategic Services and Quality. A faculty member in the University of Washington's Master's of Health Administration Program, Hereford is in charge of technology, quality, and human resources and supporting operational and clinical improvements.
- **Richard Magnuson** joined Group Health as Chief Financial Officer in 2007. Prior to this position, he worked as CFO for Fletcher Allen Health Care in Burlington, VT, and Abbott Northwestern Hospital in Minneapolis.
- **Peter Morgan** is Executive Vice President of the Group Practice Division, a role he took on in 2005. A former CPA and consultant, Morgan joined as a finance director in 1992. Among the roles he has held at Group Health: administrator for Central District and administrator for Primary Care.
- **Robert O'Brien**, Executive Vice President of the Health Plan Division, is responsible for new product development, marketing, health plan administration and operations. Previously, he worked as a consultant for Mercer Consulting where he led the health and benefits consulting business for the Seattle office.
- **Marc West** is Executive Vice President for Group Health Permanente. Prior to that, he was Group Health Permanente's Chief Financial and Administrative Officer, a director of regional finance and planning, and manager of business systems.
- **Rick Woods** serves as Executive Vice President and General Counsel, where he oversees legal, risk management, compliance, and ethics. He's been with the organization since 1988 and became general counsel in 1997. Prior to Group Health, he was Assistant Attorney General for the State of Washington. ¤

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What any change needs is real leadership, says David Feinberg, CEO of the UCLA Hospital System. "There are hard issues to be discussed, like rationing healthcare. Should every hospital do transplants or should there be centers of excellence? The problem is that some of these things are money makers for hospitals and they want to get into cardiac surgery or transplants. But that doesn't make sense."

He also thinks that Congress will talk about creating a case rate payment system – where you pay for a heart valve patient's entire care for a year, rather than based on every episode of care related to that single event. "We do that already for certain conditions, like transplants."

David B. Snow, Jr., Chairman and CEO of the pharmaceutical management company Medco, says whatever happens, costs have to be reduced. "We're spending nearly $7,000 per year per person," he says. Whatever we do has to focus on two things: a protocol-driven, evidence-based system and promoting healthy lifestyles through prevention and wellness.

Part of that will be new technology, says Joseph Rubinsztain, CEO of gMed, a Weston, Fla.-based electronic medical records company. The president calls for computerizing all medical records within five years and Rubinsztain thinks that's possible "if the healthcare industry focuses on interconnectivity. With the government, consumers, and physicians pushing to connect different health records, we could create longitudinal electronic health records and improve the quality of health care while lowering its cost." ¤

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