Nightingale's Healthcare News

inside

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Healthcare Reform Just a Vote Away?

Stimulus and Budget Bills Go Heavy on Healthcare

by Lisa Jaffe Hubbell

Among the first pieces of legislation for which President Obama is responsible are two that could have the biggest impact on the U.S. healthcare system in generations. The first, the American Recovery and Reinvestment Act – the so-called stimulus package – was voted into law in early February and included tens of millions of dollars for healthcare.

Among the key elements of the stimulus bill that relate to healthcare:

- $19 billion to get more physicians and hospitals to adopt modern health information technology systems and thus reduce costs, improve quality, and prevent potentially life-threatening errors. It is anticipated that this could lead to thousands of jobs in high-tech industries and reduce costs by $12 billion over 10 years. There is additional money in the

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Gainsharing Making a Comeback

Gets New Look as Way to Lower Healthcare Costs

by Steve Raphael

Gainsharing is making a comeback as hospitals look for ways to reduce costs and increase quality while strengthening bonds with their physicians. The program was left for dead ten years ago, a victim of criticism that gainsharing is merely a way for the medical establishment to cherry pick healthy patients. But that attitude is changing thanks to the results garnered from at least one government-run pilot program, indicating that the program can work under certain circumstances without harming patients.

The Office of Inspector General (OIG) in the Department of Health and Human Services (HHS) defines gainsharing as an arrangement in which hospitals and other healthcare organizations promote standardization and more efficient use of expensive supplies in

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Hospitalist Penetration Exceeds 50 Percent

Lean Economy Highlights Benefits of Inpatient Programs

by Lisa Jaffe Hubbell

Go to a hospital these days and chances are almost 6 in 10 that you'll be cared for by a hospitalist while you're an inpatient. Hospital medicine is a subspecialty of internal medicine in which physicians specialize in caring for patients solely in a hospital setting, replacing the dreaded rounds of primary care physicians with continuous on-site care. They rarely see patients on an outpatient basis and are often the physicians responsible for unassigned or uninsured patients without regular physicians.

In less than 15 years, the number of working hospitalists has increased to about 28,000, according to the latest survey of the Society of Hospital Medicine (SHM). Among the other findings of the biannual survey of nearly 5,000 hospitals:

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proposed budget for health IT expansion and adoption.

- $87 billion over two years to help states maintain their Medicaid programs.
- Expansion of COBRA insurance for those who lose their jobs by providing a 65 percent subsidy for up to 9 months.
- $1 billion for a new Prevention and Wellness Fund and $1.1 billion for comparative effectiveness research to evaluate the relative efficacy of various treatment options. The latter program has additional funding in the proposed budget.
- $10 billion for the National Institutes of Health, including expanding research into diseases like Alzheimer's, Parkinson's, cancer, and heart disease, as well as for improving National Institute of Health (NIH) facilities. It's thought that this will also lead to significant job creation.

The budget has yet to be finalized and may change significantly between now and when the President signs the final measure. Obama's initial pass, however, includes billions for healthcare and health-related activities. Among the funding highlights of the proposed budget, according to the Department of Health and Human Services are:

- $6 billion for cancer research at the NIH. The goal is to double cancer research funding over several years.
- Funding for the Indian health system, including sustained investments to address health disparities among Native American and Alaskan Native populations.
- $330 million to fund healthcare professionals in areas with chronic shortages.
- Funding for a nurse home visitation program for first-time mothers.
- $1 billion for the FDA to improve food safety efforts, increase inspections, increase lab capacity, and improve domestic response to prevent and control food borne illnesses.
- A reserve fund of $630 billion over 10 years to finance fundamental reform of the healthcare system. Half the funding will come from new revenue – such as letting the Bush tax cuts expire for those earning over $250,000 per year – and half by saving money through improved efficiency and cutting costs.
- Temporary incentive payments for physicians participating in Medicare starting in 2011 for using electronic health records. Starting in 2015, there will be penalties for physicians who participate in Medicare who opt not to use such technology.
- Support for the FDA to come up with a way for Americans to buy safe and effective drugs from other countries and to establish new regulations to approve generic biologics.
- Changes to the Medicare Prescription Drug Program, Medicare Advantage, and Medicaid that will allow the Centers for Medicare and Medicaid Services to identify overpayments faster and correct problems sooner.
- Additional money to the Medicare and Medicaid budget for research purposes and for new demonstration and pilot projects that could improve quality and lower costs.
- Increased funding for HIV/AIDS, particularly in underserved populations.
- $211 million for research on, and support of, those with autism spectrum disorders.
- $73 million to improve access to healthcare in rural areas.
- Financial support to state, community, and faith-based efforts to reduce teen pregnancy using evidence-based models.

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order to cut costs. A percentage of the resulting cost savings is then distributed among the physicians who helped generate those savings.

"Pure gainsharing is sharing savings across the hospital with doctors with whom hospitals have no other financial relationships [such as] employment," said Marci Handler, an attorney with the healthcare and life sciences practice of Washington D.C.-based Epstein Becker & Green, P.C. (EBG). "With the focus on quality reporting and scorecards, hospitals are constantly revisiting how they can work with their doctors to reach quality goals," she added.

Industry analysts say gainsharing can help counter the considerable waste in the healthcare delivery system that results from a lack of economic integration between hospitals and physicians. Under the best arrangements, physicians can earn up to 50 percent of the cost savings achieved in a single year.

Last year, the OIG issued six advisory opinions addressing gainsharing arrangements that involved cardiovascular services at four hospitals. After comparing the services provided at the four hospitals with hospitals that did not have gainsharing arrangements, the OIG concluded that gainsharing didn't harm patients, stifle access, or encourage kickbacks to physicians. For example, the OIG said that gainsharing cut costs at one hospital by 7.4 percent, or $315 per patient, most of which came from lower prices for coronary stents. Researchers concluded that nationwide implementation of gainsharing could cut hospital costs for coronary stent patients by roughly $195 million a year.

The OIG opinion assured the hospitals that they would unlikely face civil monetary penalties or accusations of violating the Stark and CMS anti-kickback statutes for making these arrangements. That's because the hospital had provided well-detailed rules tied to measurable clinical measures. For example, the rule allowed anesthesiologists to use a cheaper type of catheter in 90 percent of their cases.

The opinions represented a comeback for gainsharing. The government wasn't always so embracing of the concept. As recently as 1999, OIG issued a special advisory bulletin warning that gainsharing programs violated the federal anti-kickback statute, the Stark physician self-referral law, and the civil monetary penalties provision of the Social Security Act. The latter prohibited hospitals from offering payments to physicians that either directly or indirectly encouraged them to reduce or limit care for Medicaid or Medicare patients.

OIG's opposition has slowly eroded since. In 2005, the Medicare Payment Advisory Commission recommended that Congress grant HHS the authority to allow gainsharing arrangements between physicians and hospitals, as long as such arrangements maintained quality of care and did not affect physician referrals. Also in 2005, the Deficit Reduction Act required HHS to establish a three-year Medicare Hospital Gainsharing Demonstration to test and evaluate gainsharing methodologies and arrangements between hospitals and physicians.

"OIG has come far in the last decade," said Carrie Valiant, who co-chairs EBG's healthcare fraud group. "We are in a better place than we were before. OIG recognizes that appropriately structured programs provide cost savings as long as there is quality of care."

Though the OIG's advisory opinions focused on cardiology, Valiant believes that other specialties that use procedures and rely on medical devices in those procedures would also likely benefit

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Research Report

Who's Who in CVS Caremark Corporation and Longs Drug Stores Corporation

by Francoise C. Arsenault

CVS Caremark Corporation (CVS Caremark) is an integrated pharmacy services provider. The company provides pharmacy services through its stores; its pharmacy benefit management, mail order, and specialty pharmacy division, Caremark Pharmacy Services; its retail-based health clinic subsidiary, MinuteClinic; and its online pharmacy, www.cvs.com. CVS/pharmacy is the nation's largest retail pharmacy chain, with approximately 6,800 stores in 41 states. With more than 40 years in the retail pharmacy industry, CVS/pharmacy generates more than 68 percent of its revenue from the pharmacy business. CVS/pharmacy fills or manages more than 1 billion prescriptions annually. The company's ExtraCare program has more than 50 million cardholders, making it the largest retail loyalty program in the country. Caremark Pharmacy Services, one of the nation's leading pharmacy benefit management companies, provides comprehensive prescription benefit management services to more than 2,000 health plans.

In 2007, CVS Caremark had sales of approximately $76 billion. CVS Caremark operates a national retail pharmacy network with more than 60,000 participating pharmacies, as well as 11 mail service pharmacies. CVS Caremark, which is headquartered in Woonsocket, Rhode Island, has about 200,000 employees. The company is the largest employer of pharmacists and nurse practitioners in the United States.

Headquartered in Walnut Creek, California, Longs Drug Stores Corporation (Longs Drug Stores) operates in two primary business segments: Retail Drug Stores and Pharmacy Benefit Management. The Retail Drug Store segment includes a wide assortment of products and services, including healthcare products, photo and photo processing services, cosmetics, greeting cards, food and beverage products, housewares, toiletries, mail centers, and seasonal merchandise. The Pharmacy Benefit Management segment provides a range of services, including pharmacy benefit plan design and implementation, formulary management, claims processing, and generic product substitution.

As of May 2008, Longs Drug Stores operated 516 retail drug stores in the western United States. In 2007, Longs Drug Stores had sales of approximately $5.2 billion and 21,900 workers.

CVS Caremark and Longs Drug Stores announced on August 12, 2008, that they had entered into a definitive agreement under which CVS Caremark would acquire Longs Drug Stores for $71.50 per share in cash, for a total purchase price of $2.9 billion, including the assumption of net debt. Through the acquisition, CVS Caremark acquired all of Longs Drug Stores retail outlets in California, Hawaii, Nevada, and Arizona, as well as its Rx America subsidiary, which offers prescription benefits management services to more than 8 million members and prescription drug plan benefits to approximately 450,000 Medicare beneficiaries. The acquisition closed on October 30, 2008. Following the merger, Longs Drug Stores became an indirect, wholly owned subsidiary of CVS Caremark.

The combination of the two companies will expand CVS Caremark's position as the nation's leading provider of prescriptions. More than 490 of the stores acquired by CVS Caremark are located in the Central and Northern California and Hawaiian markets, where Longs Drug Stores has been the leading player. With the closing of the acquisition, Longs Drug Stores in the continental United States will be converted to the CVS brand. Longs Drug Stores in Hawaii will retain the Longs' brand.

Transaction Professionals

Thomas M. (Tom) Ryan is Chairman of the Board, President, and Chief Executive Officer of CVS Caremark Corporation. **Dr. Troyen A. Brennan** is Executive Vice President and Chief Medical Officer. **David B. (Dave) Rickard** is Executive Vice President, Chief Financial Officer, and Chief Administrative Officer. **Nancy Christal** is Senior Vice President for Investor Relations. **Douglas A. Sgarro** is Executive Vice President and Chief Legal Officer.

Warren F. Bryant is Chairman of the Board, President, and Chief Executive Officer of Longs Drug Stores. **Steven F. McCann** is Executive Vice President and Chief Financial Officer. **Todd J. Vasos** is Executive Vice President and Chief Operating Officer. **William J. Rainey** is Senior Vice President, Secretary, and General Legal Counsel. **Devang B. Shah** is Senior Corporate Counsel.

Davis Polk & Wardwell served as outside legal counsel to CVS Caremark on the transaction. **Louis L. Goldberg**, a partner in the firm's Corporate Department, worked on the acquisition along with partners **John D. Amorosi**, **Michael T. Mollerus**, **Barbara Nims**, **Edmond T. FitzGerald**, and **James A. Florack**.

Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. represented CVS Caremark in obtaining regulatory clearance from the Federal Trade Commission and on the healthcare regulatory, real estate, and environmental aspects of the transaction. **Bruce D. Sokler**, a partner, led the antitrust team and **Susan Berson**, also a partner, advised on healthcare regulatory aspects. Partners **David Alin**, **Stephen Friedberg**, and **David A. Gilbert** provided counsel on real estate matters and partner **Susan P. Phillips** handled environmental issues.

Wachtell, Lipton, Rosen & Katz served as the legal counsel to Longs Drug Stores. Partners **Joshua M. Holmes** (Tax), **Joseph D. Larson** (Antitrust), **David E. Shapiro** and **Edward D. Herlihy** (Corporate), and **Jeannemarie O'Brien** (Executive Compensation and Benefits) worked on the acquisition.

Dewey & LeBoeuf LLP provided legal advice to the financial underwriters of the acquisition. **Michelle B. Rutta**, a partner with in the firm's Corporate Group, worked on the transaction.

Barclays Capital (Lehman Brothers) served as the financial adviser to CVS Caremark and provided bridge loan commitments. **Andrew R. Taussig**, head of Retail, led the team.

Deutsche Bank AG also acted as the financial adviser to CVS Caremark. **Keith Wargo**, Co-Head Global Consumer Group, Investment Banking, and **Keith Pelt**, a director, led the team.

J.P. Morgan Securities Inc. provided Longs Drug Stores with financial advisory services. **Charles Edelman**, former Chief of Mergers and Acquisitions at Bear Stearns, led J.P. Morgan's team.

Kekst and Company acted as communications consultant to Longs Drug Stores. **Andrea E. Calise**, a partner with the firm, led the engagement. She was assisted by **Melissa Sheer**.

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• Funds for drug treatment programs and drug courts, and enhanced emergency care systems.

So how is the healthcare community reacting to the stimulus and budget packages? The American Medical Association's (AMA's) response included positive reaction to the money for healthcare information technology, noting that it is the first "substantial federal funding provided to help physicians implement HIT systems – systems that will generate benefits across the health care spectrum." The Association doesn't even gripe too much about the potential 1 percent payment penalties starting in 2015 for those who don't adopt electronic health records, pointing out that there are exceptions for extreme hardship cases.

The Association discourages physicians from feeling like Big Brother will be watching over them to make sure they do what the government says. "There is no such authority in the legislation," the response on the association's website notes. The statement goes on to say that the stimulus bill is just a start and that more has to be done. At press time, there was no commentary available from AMA officials on the budget itself.

George Benjamin, MD, Executive Director of the American Public Health Association, says that he's particularly pleased with the reserve fund dedicated to health reform and the emphasis on prevention.

Nurses are also applauding the two pieces of legislation. The American Nurses Association says the budget makes them especially happy, and President Rebecca Patton, MSN, is particularly pleased that there is money to strengthen the healthcare workforce, including increasing the capacity at nursing schools to help address the ongoing nurse shortage.

The American Hospital Association (AHA) is one of the only organizations to applaud less than enthusiastically. While commending President Obama for making health reform a priority, the AHA is "concerned about any cuts that would affect the work hospitals do for their communities during this economic downturn."

Given the nature of politics, however, all of these organizations are likely to have at least one completely different set of figures to comment on before a final bill is signed. ¤

Gainsharing, *from page 2*

from gainsharing programs.

Handler said that such measures as "open-as-needed" items would significantly decrease costs and not adversely affect quality.

Gainsharing is not a slam dunk, however. "If you've seen one gainsharing program, you've seen one gainsharing program," Valiant said. "The more complicated the arrangement, the more you're trying to put a square peg in a round hole in terms of regulatory compliance."

"Congress is not too wild about gainsharing…in particular Pete Stark," she added. "He called it misguided and dangerous and, if there is money to be saved, hospitals should give it back to Medicare. He reportedly is the main reason why we don't have a final gainsharing arrangement."

Of course if you aren't using a gainsharing program there isn't any savings to return to the government, Valiant observed.

Just because the government hasn't finalized its gainsharing exceptions does not mean hospitals are powerless to go forward with their own programs. "If people stay within the rubric that already has government assurance, it is less likely that gainsharing arrangements will be viewed as problematic," Valiant said. "Hospitals have to ask themselves whether an advisory opinion from the OIG is something they want to spend the time and energy to get."

Handler and Valiant advise their clients to make sure their arrangements have guidelines that will help protect the participants when the government knocks on the door. "Any measure that reduces care has to be thought through carefully," Handler added. ¤

Hospitalist, *from page 1*

• Hospitalists are in about 83 percent of hospitals with more than 200 beds.

• The average hospitalist program has about 10 physicians – up from about 8 in 2006, when the last survey was released.

• Hospitalists increased in number by about 20% between 2006 and 2007.

• Increasingly, hospitalists are working for hospitals or hospital groups and fewer are working in their own private hospitalist practices.

• While a quarter of hospitalists are on a straight salary program, 70 percent are paid based on a mix of salary and productivity or performance-related pay.

• A continuing shortage of hospitalists has led many programs to hire nurse practitioners (26 percent) or physician assistants (21 percent) – both of these figures are up from the previous survey (20 percent and 16 percent, respectively)

• The percentage of hospitals subsidizing hospitalist programs declined from 60 percent to 50 percent.

The last statistic is probably understandable considering the economy, says Larry Wellikson, MD, Chief Executive Officer of the SHM. "Hospitals are seeing a worse payer mix, a lot more patients without insurance, and they can't borrow any money. They have less discretionary money to spend."

But hospitals should take care to ensure their hospitalist programs can continue to function financially, he says. "A well-functioning hospital medicine program does more than just see patients," says Wellikson. They take on leadership and quality improvement duties; they work on team building and help implement new programs. "But if you can't grow your hospitalist program, then what will suffer is the other stuff we do, or we'll have to do more work for less pay – work 18 or 20 days a month instead of 16. We might not be able to take care of surgical patients and limit ourselves to family practice patients only."

That, in turn, could make the hospital's surgeons unhappy. Or it could make the hospitalists themselves less satisfied with their jobs and, given the continued growth of hospitalist programs, there is no shortage of places for an unhappy hospitalist to go. "It's a real dilemma for a hospital, especially if you operate in a county with a lot of hospitals and health systems," Wellikson says. "There is a lot of choice for good doctors."

Wellikson doesn't see any decline in the penetration of hospital medicine, regardless of how long the economy is in recession. "There just isn't an option not to implement a hospital medicine program anymore," he says. "The demand for primary care physicians, subspecialists in the emergency department, and surgeons is overwhelming. We aren't going anywhere." He likens the rise of hospitalists to the similar development of emergency medicine as a specialty 30 years ago. "Emergency departments didn't go anywhere in a recession. We won't either."

What is more likely is that primary care physicians, who are

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Special Report

Selected Healthcare Consulting Firms – 2009

Firm	Key Professionals	Services Offered	Clients
California Healthcare Consulting Group San Clemente, CA Tel. (949) 481-9066 www.healthcareconsultant.org	Kim Fenton Steve Crane Melissa Christian Maryam Kerl	Managed healthcare contracting, health plan negotiations, practice assessment, business analysis, revenue optimization, physician credentialing, staff training, implementation.	Physicians, specialists, healthcare institutions.
EBG Advisors, Inc. Washington, DC Tel. (202) 861-1380 www.ebgadvisors.com	Teresa Brooks Paul Campbell Ted Mannen	Reimbursement planning for new and mature devices and drugs; collection and synthesis of healthcare knowledge for private-equity firms and other investors; public policy assessments and analyses for corporate and association government affairs and policy professionals.	Healthcare service providers, bioscience innovations developers, trade associations, coalitions and alliances, private-equity and investment firms.
Formation Strategies Kansas City, MO Tel. (816) 753-5881 www.formationstrategies.com	Ron Bremer Kathy Bremer Michelle Kruse Michelle Jerred	Comprehensive real estate and facility solutions for healthcare organizations that include strategy, program management, development, and capital.	Hospitals, health systems, MOBs, ASCs, ACC, academic medical centers, LT care, cancer centers, parking.
Fountainhead, LLC Denver, CO Tel. (720) 570-8063 www.fountainhead-llc.com	Brian E. Hoyt	Data analysis, reporting claims, payments disputes, Medicare reconciliations, self-disclosures to Medicare, FEHBP rate audits, statistical analysis, litigation services, economic damage analysis, lean six sigma process improvement fraud investigations.	Engaged by in-house counsel at healthcare entities (health plans, hospitals, or provider groups) or by the law firms representing them in disputes or internal investigations.
Health Capital Consultants St. Louis, MO Tel. (800) FYI-VALU www.healthcapital.com	Robert James Cimasi Todd Zigrang Anne P. Sharamitaro	Valuations, provider integration, financial analysis, certificate of need and regulatory consulting, litigation support and expert witness services.	Hospitals, health systems, academic medical centers, cancer centers, law firms.
Kaufman Hall Skokie, IL Tel. (847) 441-8780 www.kaufmanhall.com	Kenneth Kaufman Mark Hall Andrew Majka	Debt and derivatives-related advisory services; strategic financial and capital planning services; capital allocation and decision making services; merger, acquisition, real estate, and joint venture services.	Healthcare provider organizations of all types and sizes including hospitals and health systems.
MCPP Healthcare Consulting Seattle, WA Tel. (206) 613-3339 www.mcpphealthcare.com	Dale Jarvis Barbara Mauer Marlene Mason Diane Altman Dautoff	Clinical, business and strategic planning, finance and information technology, performance measurement and improvement, practice management.	Medical practices, behavioral health providers, public health agencies, provider networks and associations, mental health authorities, health plans.
Medco, Inc. Willow Grove, PA Tel. (215) 659-9311 www.medcohlth.com	J. Earl Wivell David B. Kingsley	Operations assessment, focused improvement, performance management, perioperative services, service consolidation analysis.	Healthcare systems, acute care hospitals, behavioral health and rehabilitation systems.
Somerset CPAs – Health Care Team Indianapolis, IN Tel. (317) 472-2200 www.somersetcpas.com	James Hamilton Reggie Elkins Charles H. Mason, Jr. David Oster	Strategic/succession planning, income distribution design, business process and revenue cycle management, feasibility studies, valuations, operational reviews.	Hospitals, health systems, private practice and hospital-based physician groups, ancillary service providers, surgery centers, imaging centers.
Stroudwater Associates Portland, ME Tel. (800) 947-5712 www.stroudwater.biz	Mark Voyvodich David Whelan Joseph Lupica	Performance improvement initiatives, financial and operational analysis, strategic and business planning, clinical service line development.	Academic medical centers, health systems, health plans, community and rural hospitals, physician groups.

Worth Reading

A Hundred Years of Medicine

Authors: C. D. Haagensen and Wyndham E. B. Lloyd
Publisher: Beard Books
Softcover: 460 pages
List Price $34.95

Review by Henry Berry

A Hundred Years of Medicine is presented in four parts. Part I discusses the historical background of modern medicine, which is considered to have begun in England around the middle of the 1700s. About half of the chapters in Part II on the history of infectious disease remain, for the most part, as Lloyd wrote them. The other half of Lloyd's chapters in Part II and all of Part III, "Surgery During the Last Hundred Years," and Part IV, "New Social Aspects of Medicine," have been entirely rewritten by Haagensen. Haagensen's extensive 2000 update of Lloyd's original 1943 work is in keeping with that author's original intention that his "historical essay may prove to be of value not only to the layman [its primary audience]...but also to those medical practitioners and students who have not found time for any specialized study of the history of medicine."

This book is not presumed nor intended to be comprehensive. Lloyd remarks in the preface to the original edition that his intent is to present the subject matter in a manner that is not "too technical [for] the non-medical reader." However, *A Hundred Years of Medicine* does provide a thorough discussion of medical issues, including advances in surgery during this time, that the reader is certain to find fascinating.

Part I, a general history of medicine titled "Medicine Up to a Hundred Years Ago," demonstrates the progress that has been made in the medical field, including the contributions of its primary professionals (doctors) and institutions (hospitals). Hospitals, which became prevalent in the eighteenth century, were not only centers for the treatment of medical problems, but also served as places for conducting scientific and research studies that would further the field of medicine. Part I also contains a broad historical section that sets the context for the advances in understanding and treatment of disease and the major improvements in surgical procedures during the nineteenth and early twentieth centuries.

In the second and third parts, on diseases and surgery respectively, the reader learns that "important medical advances are not made in a single day but are generally the result of a laborious series of steps made by a number of different workers over long periods of years." It is here that the book moves from a historical treatise to a discussion of particular medical conditions and their treatments. Lloyd and Haagensen illuminate the developments in chronological order so the reader can appreciate the challenges, breakthroughs, and notable junctures in medical and surgical achievements. The authors also follow, however, parallel developments in other areas of medicine that, taken together, portray the forward movement of the entire medical field. In line with this approach, the general subject of disease in Part II is delineated into chapters on the three main areas of developments of germ theory: ineffective organisms, germs outside the body, and germs inside the body. Also found in this part are separate chapters on the introduction of chemotherapy; the campaigns to combat tuberculosis, diabetes, and anemia; and the role of vitamins in preventive medicine.

The nineteenth century was notable for the large strides made in the recognition, diagnosis, and treatment of disease. At the core of this advancement was the discovery of the animal cell. This, in turn, led to the conception of the living body as a vast organization consisting of millions of tiny individual cells. This view, which came to be known as Cell Theory, quickly spread throughout the medical field because it answered centuries-old medical mysteries and gave doctors scientifically-based guidance for identifying and treating diseases. Eventually it led to developments in disease prevention and public sanitation for individuals and governments. First posited little more than one hundred years ago, Cell Theory remains the basic principal of today's medical field by which doctors are educated and trained and diseases are treated.

In recent decades, Cell Theory has led to remarkable progress in the treatment of cancer and one day may result in a cure for it, as tuberculosis and polio were cured in earlier times.

The authors similarly cover the historical turning point in the field of surgery. Surgery is considered the "opening of the great cavities of the body, the abdomen and chest...to operate upon the viscera." Before the early 1800s, medical treatment had been limited to dealing with wounds and diseases on the "surface of the body and in the extremities." There were no doctors called surgeons as such. But in 1809 in his home in Danville, Kentucky, where he had begun his practice in 1795, thirty-eight-year old Ephraim McDowell removed a twenty-two and a half-pound ovarian tumor from a woman in what was the first surgery lasting twenty-five minutes without anesthesia. It was seven years before McDowell performed another ovariotomy, and not until the 1820s before other doctors performed the operation. With the introduction of anesthesia in the early 1840s, surgery quickly moved into new areas and developed rapidly.

With such engaging, sometimes dramatic material and portrayals of the pioneers of medicine, *A Hundred Years of Medicine* offers a readable and memorable history of medicine. ¤

Special Report

Outstanding Physician Practice Lawyers – 2009

Attorney	Firm	Outstanding Achievements
Thomas W. Baker	Baker, Donelson, Bearman, Caldwell & Berkowitz, PC Atlanta, GA Tel. (404 221-6510 tbaker@bakerdonelson.com	Advised joint venture pathology lab company serving hospitals, ambulatory surgery centers, and other healthcare facilities located in underserved areas; organized limited liability companies to provide capital from sources other than the practicing physicians, who might not be restricted under the professional corporations code.
Paul R. DeMuro	Latham & Watkins Los Angeles/San Francisco, CA Tel. (213) 891-7330 paul.demuro@lw.com	Represents hospitals, health systems, physicians, physician groups, physician practice companies, integrated health systems, managed care organizations, e-health care and healthcare technology companies. Clients include Sheridan Healthcorp, one of the largest privately held physician groups and practice management companies in the U.S.
Laura Gage	Foley & Lardner Milwaukee, WI Tel. (414) 297-5651 lgage@foley.com	Counsels clients on compliance issues and specializes in the transactional aspects of healthcare law. Analyzes contractual arrangements for compliance with fraud and abuse laws and physician self-referral restrictions. Represents clients in general corporate matters, partnership restructuring, joint ventures, and the dissolution of practices.
Thomas Greeson	Reed Smith Falls Church, VA Tel. (703) 641-4242 tgreeson@reedsmith.com	Counseled physician groups in complying with new diagnostic imaging provider regulations. Represented radiology groups renegotiating hospital professional services agreements. Restructured hospital-radiology group from Part B entities paid under Medicare Physician Fee Schedule to qualify as hospital provider-based entities.
Kelley Taylor Hearne	Drinker Biddle & Reath LLP Washington, DC Tel. (202) 230-5127 Kelley.Hearne@dbr.com	Represented physician groups in sale of dialysis centers to leading national dialysis management companies. Counseled physicians in negotiating medical director agreements. Played key role in reorganizing one of the largest private group physician practices in the U.S., with over 700 physicians, into an integrated delivery system.
Bruce Johnson	Faegre & Benson LLP Denver, CO Tel. (303) 607-3620 BAJohnson@faegre.com	Assisted medical groups and other healthcare organizations in regulatory compliance activities, including Stark law. Advised tax-exempt organizations, including hospitals and academic practices, regarding physician/hospital collaborative strategies. Facilitated planning, development, and implementation of group practice formation and mergers.
Kerry M. Parker	Epstein Becker & Green Newark, NJ Tel. (973) 639-8259 kparker@ebglaw.com	Successfully represented radiology group suspecting office manager of embezzlement and possible Medicare billing fraud. Successfully represented an anesthesia practice in Medicare audit and recoupment. Represented an OB/GYN practice in litigation and arbitration involving a former partner who withdrew from the practice.
Anthony D. Shaffer	Schottenstein, Zox & Dunn Columbus, Ohio Tel. (614) 462-2270 ashaffer@szd.com	Helped three oncology groups combine into one practice and develop a state-of-the-art $28 million regional comprehensive cancer treatment facility. Lead attorney and negotiator for the sale of major cardiology practice to a regional health system. Counsel in the development of several hospital-affiliated physician groups and networks.
Stephanie Wall	K&L Gates Pittsburgh, PA Tel. (412) 355-8364 stephanie.wall@klgates.com	Negotiated and drafted joint venture arrangements, physician recruitment deals, exclusive "house-based" physician agreements, management and consulting agreements, employment agreements, medical director agreements, asset purchase and stock deals, and shareholders' agreements. Advised on Stark and other healthcare regulations.
Robert L. Wilson, Jr.	Smith Moore Leatherwood Raleigh, NC Tel. (919) 755-8823 bob.wilson@smithmoorelaw.com	Counseled large physician groups dealing with practice management divestitures, corporate practice, contracts, and related issues. Represented hospitals in developing physician recruitment strategies and arrangements. Has special interest in legal and practical issues involving hospital-based physician contracts for hospitals and physicians.

In Focus

The Center for Healthcare Governance

The Center for Healthcare Governance is an affiliate group of the American Hospital Association (AHA). It serves as a resource for hospitals in the areas of corporate governance, education, research, and best practices, and provides a variety of publications, courses, consultants, and peer-to-peer networking. Members have access to governance experts, self-assessment tools and resources, and publications. The Center offers programs – on and off-site – for CEOs, board members, executive leadership, and medical staff.

Among the curricula offered are two annual multi-day symposia that cover the full spectrum of governance and leadership topics. There are also single-day conferences offered in conjunction with American Hospital Association and Health Forum meetings and leadership conferences and retreats. The Center is also working with state hospital associations for co-hosting conferences that focus on specific issues or professional development topics.

For members looking for more immediate help, the Center has Speaker Express, a customized service that matches speakers with organizations. Topics include everything from patient safety and ethics to quality and hospital/physician relationships.

Members also can access specific quality curriculum developed for hospital trustees and board members; consultants who can assist with specific issues; research and assessment services to help identify challenges facing hospitals or health systems; a governance assessment process (GAP) to assess the performance of hospital and health plan boards; custom research; and governance surveys. The latter are done in partnership with the AHA's Health Research and Educational Trust (HRET) and are a series of short online surveys to help provide quick benchmarks of current practices and emerging trends. Among the topics: the credit crisis and the board, physician/board relationships, executive sessions, and trustee demographics.

The Center also works with members on trustee recruitment, particularly in the search for qualified people from diverse ethnic and cultural backgrounds. Using the AHA's minority trustee candidate registry, members can access a pool of candidates who have already participated in AHA educational programs.

Other online resources include sections on director recruitment, board performance metrics, compensation practices, and strengthening community relationships. These include sample committee charters, sample policies and procedures, role descriptions, and other articles. There are also workbooks written by governance experts that are published in issues of *Trustee* magazine, one of the publications the Center offers. Past topics include physicians in governance and maximizing board performance. There are also best practices from member hospitals available for members.

Among the most recent achievements of the Center is the release of a report, *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness,* put together by the Blue Ribbon Panel on Trustee Core Competencies and funded by Hospira, Inc. The report includes recommendations for hospital boards of trustees, educators, and researchers to better understand and practice competency-based governance.

The Center is assisted in its own governance by a national board of advisors, including hospital CEOs and trustees, physicians, academics, executives from the American Hospital Association, and state hospital association leaders.

Among the key staff working on day to day operations are:

- **Don Wegmiller**, Chairman, National Board of Advisors**.** A nationally renowned advocate for quality and accountability in health care for nearly 40 years, Wegmiller served as the first Chairman of the National Board of Advisors. He is currently President and Chief Executive Officer of HealthCare Compensation Strategies.
- **John R. Combes, MD**, President and Chief Operating Officer. Combes is responsible for staffing and administration, sponsorship development, the national symposia, regional conferences, and membership development. He has more than 20 years of experience in executive healthcare leadership with expertise on issues relating to quality, patient safety, and medical ethics. Combes previously served as a senior medical advisor at the Hospital and Healthsystem Association of Pennsylvania and the American Hospital Association and was a chief medical officer for two large Florida healthcare systems.
- **Gene J. O'Dell**, Vice President, Development and Operations. O'Dell oversees implementation of organizational growth strategies and executing the daily operations of the Center. He brings 18 years of healthcare strategic planning and business development-related experience, including positions at BJC HealthCare, St. Louis. O'Dell also serves as Vice President of Strategic and Business Planning for the American Hospital Association.
- **James E. Orlikoff**, Senior Consultant. Orlikoff is the National Advisor on Governance and Leadership to the American Hospital Association and Health Forum and a founding editor and publisher of *Health Governance Report*.
- **Mary K. Totten**, Director of Content Development. Totten covers leadership issues and trends for health care organization board members. ¤

Hospitalist, *from page 4*

seeing a continuing decline in their income, will leave practice prematurely. "If they have to do more work for less money, they'll leave. That leaves us with the problem of where we send our patients on discharge," Wellikson says. "We may end up becoming default caregivers and have to have outpatient clinics in the hospital setting a couple times a week."

Hospitalists produce better results, improve throughput, and keep the emergency department from getting overcrowded, he concludes. "You have to squeeze out inefficiencies, and that's what we do. We reduce readmissions and emergency department visits from recently released patients. That's an efficiency. The problem is that hospitals make money on that. There is an element of reward for inefficiencies and, for that to change, we'll have to wait for whatever revamping of healthcare the new administration brings." ¤

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