

**Healthcare Organizations:**  
**[Journal of Financial Management Strategies]**  
**November 2009 Newsletter**



**MERRY CHRISTMAS, HAPPY HOLIDAYS  
AND NEW YEAR 2010**

**Welcome to the Renaissance**

As we soon begin 2010 and the fifth calendar year for **Healthcare Organizations [Journal of Financial Management Strategies]**, please allow us to enhance our publication going forward, with this editorial and executable Renaissance of-sorts.

We're proud of our achievements to date and especially pleased that **Healthcare Organizations [Journal Financial Management Strategies]** has grown steadily since inception, in 2006. But, we operate in the health economic ecosystem - one of intense time and cost constraints - of relentless change and competitive innovation. Just as movement is life, to become a static periodical is to become obsolete.

And, much like science historian Thomas Kuhn who posited that paradigm shifts are never easy - and with the desire to flourish and to ethically serve you at the *intersection of medical mission and profit margin* - we've spent the last year asking our subscribers what they need and want from us in the coming year. And, we've determined that we can achieve your goals faster and more deeply with the following three improvements:

1] **You're busier than ever as your CXO, BOD and/or stake-holders pressure you for increased market share and R.O.I. Therefore, you want us to be brief but actionable on the quarter's most important financial management and health economic news, information and ideas; delivered as intelligently and efficiently as possible.**

So, we're providing you with an enhanced version of our popular News Release and Newsletter, and will cull its content from an increasingly diverse range of resources that are reliable and illuminating. We will continue with the occasional complimentary electronic treatise, essay or white-paper too, as exemplified by our glossary updates, etc.

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**2] You consume health economics information voraciously and much differently than before, as you graze through - or hurry past - financial reports in trade-journals, seminars, websites, pod-casts, mobile devices and industry sponsored magazines. Some is vital, some not.**

So, in all premium digital issues of **Healthcare Organizations** [*Journal Financial Management Strategies*], we'll be focused like a laser on triaging, reporting and analyzing "need-to-know" material. But, we will also be opening our doors to internet information and timely knowledge aggregation through our website, polls, text-messages, blogs, forums and various new-wave collaborative communication channels. In other words, we will join in on your cogent conversations about us - as we all learn from other protean and multi-disciplined experts - and share helpful ideas found worthwhile by those in the trenches, even if not developed here. In this way, we will continue to operate at the cutting-edge intersection of academic and applied research.

**3] You are tired of style-over substance sales-pitches, and advertising-driven "unbiased" publications that purport-to-report economics information for healthcare entities.**

So, our clean and more understated digital design will feature more information, experience and wisdom organized into straightforward chapters, comprehensive sections and real-word Harvard Business School-styled Case-Models, than ever before. And, as a premium quarterly print-subscription, you will not find any advertising, marketing or sales pitches within. We promote unbiased cognitive resources and intellectual capital; not expensive products or superficial services. Since we do not have deep pockets to rely on, we must prove ourselves in the marketplace every day ... just like you!

The entire **Healthcare Organizations** [*Journal of Financial Management Strategies*] team contributed to this renaissance; from contributors and editors, to readers, technologists and promotional specialists.

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We welcome your feedback, good or bad, and firmly believe that as a result of our solid foundation and these forward-thinking changes, we now offer the most useful guide for the financial management of healthcare organizations available anywhere.

Join the Renaissance in 2010.

***Subscribe today ... Blog Online ... Succeed tomorrow!***

***PS:*** Don't forget to review-read-rave and rant online at our web-blog and new communications forum.

Fraternally,

**David Edward Marcinko**

**Hope Rachel Hetico**

**WEBSITE: [www.HealthcareFinancials.com](http://www.HealthcareFinancials.com)**

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***Subscriber Feedback***

**SEE WHAT OUR READER'S ARE SAYING ABOUT RED FLAGS**

*Even if by some miracle the Rule's deadline is delayed one more time, the Red Flag Rules are only the beginning. The security breach notification provision of the HITECH law goes into effect somewhere around mid-September. This is part of the updated HIPAA and HITECH regulations passed within the 2009 ARRA.*

*If you have a breach of 500 or more records (any electronic breach), you must submit your name to the HHS website and in major media in your region, unless you have encrypted all hard drives, portable media, etc., for data at rest (that stored on your system) and data in motion (i.e., transmitted, internally or externally).*

*So it looks like HHS will out-bully the FTC after all. Whew! That was close!*

*The good news is it is not difficult to encrypt hard drives to federal standards (found in FIPS 140-2). Windows 2000, XP Pro and Server 2003 and up have encryption capability built-in that so far, looks to be FIPS-140-2 qualified. I am awaiting confirmation from the government, which I would be happy to pass on.*

*May I add to your advice? Insurance reimbursement isn't a necessity for dentistry. Get out of it while you still can (and pray you are not part of healthcare reform). Go cash all the way. It's the best medical model out there. By the way, patients paying with credit cards do not make you obligated to the Red Flag Rule.*

*Most docs won't go back to pegboard, but it is a lovely thought. So unfortunately 2009 HIPAA / HITECH will apply. Actually, that might make you go back to pegboard.*

*HITECH is a month or so out. I expect that there will not be any HITECH delay, as people know less about HITECH than they do about Red Flag, if that's physically possible. So stink-making is probably not occurring with gusto; or at all. I digress; back to red flags.*

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*If it makes you feel any better, 78% of the physicians (not dentists) we have surveyed nationwide (granted, only a few hundred so far this week), have no idea what the Red Flag Rule is, nor do their Office Managers. So their associations aren't getting through either. We didn't have the heart to ask them if they'd heard of the new HITECH law.*

*1996 HIPAA was never enforced, cost untold millions to implement, and I don't know how much actual protection was provided. And really, from a patient's perspective, who cares about the guy who is sitting next to you in the waiting room with polyps? But, the new Red Flag Rule law might be something that patients actually care about. Financial and medical identity theft is expensive to fix for patients and doctors. Regulatory penalties aren't the half of it.*

*I don't know any doctor who wants to comply and I sympathize. However, Red Flag Rule compliance isn't that onerous a matter (OK, relative to HIPAA /HITECH) if you understand the law and its requirements.*

*Problem is, the FTC document (or association document, which is just as bad) is given to staff to execute, who have a hard time discerning what the law's crafters meant after the title. So compliance doesn't really happen, and if it does, it is with a fair apportionment of pain all around, with more doctor time spent than anyone wants to invest (which is none, I know).*

*If a government is going to insist that we do something they ought to write it so we can understand the darn thing. You practically have to be an attorney to get through anything in the Federal Register. And while I'm ranting about that, let me just add that the Red Flag Rule crafters OMIT the most vital information a doctor needs to provide some tangible protection for the practice, so that they might actually receive some benefit from all the hoop-jumping.*

*"Checking patient IDs", which is what the 3 people who've heard of the Red Flag Rule believe IS the totality of the Rule (because the FTC led them to believe it), is like closing the door of the barn after the horse has gone, found a mare and had a paddock-full of frolicking fillies.*

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*13% of identity theft is attempted by falsifying IDs at the front desk. 80% of breaches are committed by employees, who often sell it to pros, who scam insurers for big money. You don't see anyone talking about that.*

*The good news is there doesn't seem to be much chance of that with dentists, at least from the pros. You guys don't get paid enough for a professional thief to bother with. And you thought your low (or no) insurance reimbursement was a bad thing ... maybe not so much."*

**Pamela Thompson**

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## **HOSPITAL AND HEALTH SYSTEMS SUMMARY\***

*By Richard Frye; PhD  
Forte Information Resources, Denver, Co.*

*This hospital and integrated health systems summary for 2008 provides demographic, utilization and pharmacy data on hospitals and hospital systems, and reports on the wide range of hospitals, physicians, managed care organizations and other providers joining forces to form highly integrated systems.*

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### **Hospital Industry Summary**

- Of the 5,035 short-term, acute-care, nonfederal U.S. hospitals in the SDI database in 2007, 2,665 (52.9%) were part of a multi-hospital system (MHS), up from 52.4% in 2006, and from 51.8% in 2005. More hospitals are expected to shift toward MHS affiliation as a means to increase revenue streams, reduce operating costs, gain flexibility in providing services, and participate in managed care contracting.
- In 2007, MHS hospitals (\$47,847) averaged higher pharmaceutical costs per staffed bed than non-MHS hospitals (\$39,653). This gap is likely to widen, as MHS hospitals continue to perform a greater number of surgical procedures and treat more severe cases in intensive care unit (ICU) settings.
- In 2007, hospitals averaged 1,259.4 diabetes inpatient cases per year, down slightly from 1,263.4 in 2006, but still the second-highest per-hospital average of the 10 disease states profiled. Diabetes is a chronic disease that still has no cure. To maintain controlled A1c levels, diabetes patients need to be closely monitored by physicians and routinely tested. Improved persistency and compliance will be useful for managing diabetes patients with high A1c levels.

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- Of hospital inpatient cases that treated patients diagnosed with atrial fibrillation in 2007, more than three-quarters (76.3%) were paid for by Medicare, down slightly from 78.7% in 2006, but still the highest Medicare payer share, by disease state, by a notable margin. As atrial fibrillation becomes more prevalent among older populations, efforts will need to be made to promote greater care coordination between hospitals and providers. Hospitals will likewise be forced to address poor readmission rates or face reduced Medicare payments.
- In 2007, average inpatient charges per case of hypertension were \$14,430 in 2007, lowest of the 10 diseases profiled in the Digest. To control future hospital costs, physicians will most likely assume an expanded role in helping hypertension patients monitor their blood pressure and maintain their prescribed drug regimens.
- Total facility average length of stay (ALOS) fell, between 2006 and 2007, for hospitals in MHSs, regardless of HMO ownership. In order to further reduce ALOS, hospitals must continue to seek measures that improve efficiency, such as review of physician practices and better resource management.

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## Integrated Health Systems Summary

- After increasing a substantial 85.5% between 2003 (677) and 2007 (1,256), the total number of provider units in highly integrated systems with a national delivery focus plummeted 31.3% in 2008, to 863. As hospitals seek to increase their efficiency and profitability by localizing their operations, highly integrated systems will likely follow suit. The facilities that are best prepared to meet these constantly evolving demands will help shape the future role of hospitals in the health care industry.

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- In 17 of 20 MSAs selected for tracking, the numbers of discharges at hospitals affiliated with highly integrated systems were higher than at their non-system counterparts. System hospitals, which tend to be located in large metropolitan areas and house more staffed beds, should continue to treat and discharge more patients on an annual basis than non-MHS facilities.
- The number of short-term, acute-care, nonfederal U.S. hospitals in the SDI database owned by or contracted to highly integrated systems rose another 5% in 2008, to 1,914 from 1,822 the year before. The security of managed care contracting through integration will continue to drive hospitals to affiliate with systems in years to come.
- For the fifth consecutive year, the pharmacy expenditure share of total operating expenses at HMOs in highly integrated systems fell, to 13.1% in 2007 from 13.5% in 2006. Higher levels of coordination among pharmacists and physicians in system-tied HMOs are helping to improve drug adherence and tighten cost control.
- HMOs that were part of highly integrated systems dispensed 28.3 Medicare prescriptions per member per year (PMPY) in 2007, up 6.4% from 26.6 in 2006. This average was 10.5% more than that of HMOs overall (to 25.6 from 24.6 in 2006). Such growth has increased since the passage of the Medicare Modernization Act (MMA) of 2003. This ratio is expected to rise as more Medicare beneficiaries sign on to receive their prescription drug coverage from Part D.
- In seven of eight specialty categories listed, multi-specialty medical group practices were more likely than their single specialty counterparts to perform surgery in 2008. Although the compensation structure may be more complex in multi-specialty groups, many specialists, especially surgeons, will benefit under such arrangements because of the valuable referrals gained via integrated managed care organizations (MCOs).

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**THE END**

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