

HEALTHCARE BENCHMARKS

The Newsletter of Best Practices

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Higher costs and lower pay deal hospital-owned practices a blow

Hospital practices still lag behind physician-owned counterparts

Hospital-owned practices still aren't doing as well as their physician-owned counterparts in any of several key areas, according to this year's crop of compensation, production, and cost surveys from the Medical Group Management Association (MGMA).

According to the *Management Compensation Survey: 2001 Report Based on 2000 Data*, the only place where a hospital or health system-owned practice does better than others is in how it pays its administrative staff. Physician CEOs, COOs, and CFOs all make more money if they work for a hospital practice. **(See p. 134 for a sampling of compensation figures.)** Of the 24 positions in which the MGMA had enough data to produce comparative figures, in only six of them did physician-owned practice staff make more than its peers in practices owned by hospitals or health systems.

In the past year, several management positions — regardless of who owns the practice — have seen compensation declines. Physician CEOs saw a 5.58% decrease in mean compensation. Others had a bigger hit. Directors of managed care had a 14.09% decrease in average compensation, and directors of planning and development saw pay plunge by 13.61%. Some positions fared better this year, including medical directors, who saw an increase of nearly 4% in their annual compensation between 1999 and 2000. Most of the increases, however, were less than 4%, and closer to 2%.

Hospital-owned practices don't generate the same level of accounts receivable per physician or per provider. **(See p. 134 for more accounts receivable data.)** And

according to the *Cost Survey: 2001 Report Based on 2000 Data*, once there are bills to be paid, the hospital practices are not as efficient at getting the revenue in the door. Fewer bills are paid in zero to 30 days, and more of their bills remain unpaid after 120 days,

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Compensation for Selected Positions

Hospital/Health System-owned Practices vs. Physician-owned

Position	Hospital/Health System-owned	Physician-owned
Physician CEO/President	\$258,000	\$245,845
Medical Director	\$187,811	\$181,517
Chief Operating Officer	\$123,000	\$90,046
Chief Financial Officer	\$81,311	\$94,400
Director, Quality Improvement/Quality Assurance	\$56,221	\$52,335
Director, MIS/IS Manager	\$70,013	\$53,001
Office Manager	\$37,772	\$39,273

All figures are means.

Source: Management Compensation Survey: 2001 Report Based on 2000 Data; MGMA, Englewood, CO.

A/R Data – Hospital-owned vs. Non hospital-owned

	Hospital-owned	Non hospital-owned
Total A/R per physician	\$112,320	\$147,588
Total A/R per provider	\$99,427	\$118,747
0-30 days in A/R	38.66%	41.52%
31-60 days in A/R	16.75%	16.89%
61-90 days in A/R	9.42%	9.11%
91-120 days in A/R	6.85%	6.29%
120+ days in A/R	28.32%	26.20%

All figures are means; multispecialty practices only.

Source: Cost Survey: 2001 Report Based on 2000 Data, MGMA, Englewood, CO.

Perhaps the reason is that hospital-owned practices have fewer support staff than physician-owned practices — 4.59 per full-time employee (FTE) physician in the former compared to 5.50 per FTE physician in the latter. Hospital-owned practices manage to keep costs per FTE physician lower than doctor-owned practices. But total gross charges and total medical revenue per FTE physician is also significantly lower. Medical revenue after costs per FTE physician is almost half the level in hospital-owned practices as it is in physician-owned practices.

The upshot: While physicians who own their own practices earn \$479 in net income per physician (excluding any financial support that comes from parent companies or others), hospital-owned

practice physicians make a net loss of more than \$93,000. **(For more production and compensation data, see p. 135.)**

In all practices, regardless of ownership, medical revenue per FTE physician increased between 1986 and 2000 by 67.7%, from \$293,842 to \$492,648. Total operating costs per physician, however, almost doubled from \$154,884 to \$299,798 in the same period. The result is an increase in revenue after operating costs from \$133,707 to \$201,163, according to the report.

It isn't just practices as a whole that show the difference that ownership can make. In 26 of the 47 specialties in which there is adequate data to make a comparison, the *Physician Compensation and Production Survey: 2001 Report based on 2000 Data*

COMING IN FUTURE MONTHS

■ Designing an outcomes management program

■ Developing data skills

■ What is a standardized performance ratio?

■ Inside some of the 100 top hospitals in the country

Selected Cost & Revenue Data Hospital-owned vs. Non hospital-owned

Data Set	Hospital-owned	Non-hospital-owned
Support staff per full-time employee (FTE) physician	4.59	5.50
Total gross charges	\$616,239	\$876,714
Total medical revenue	\$408,879	\$591,232
Total support staff cost per FTE physician	\$146,775	\$181,726
Total general operating cost per FTE physician	\$136,281	\$175,670
Total medical revenue after operating cost per FTE physician	\$125,485	\$236,353
Total cost per FTE physician	\$502,470	\$599,863
Net income per FTE physician (excluding financial support)	\$93,174	\$479

All figures are means; multispecialty practices only.

Source: Cost Survey: 2001 Report Based on 2000 Data; MGMA, Englewood, CO.

Physician Compensation and Production Data for Selected Specialties Hospital-owned vs. Non hospital-owned

Compensation	Hospital-owned	Non-hospital-owned
Anesthesiology	\$221,366	\$281,297
Emergency Medicine	\$180,000	\$200,505
Hospitalist	\$174,186	\$141,259
Surgeon – cardiovascular	\$500,000	\$432,107
Gross Charges (tech component excluded)		
Anesthesiology	\$783,513	\$679,915
Emergency Medicine	\$456,539	\$455,043
Hospitalist	\$349,765	\$336,381
Surgeon – cardiovascular	\$1,060,305	\$1,605,676

All figures are medians; multispecialty practices only.

Source Physician Compensation and Production Survey: 2001 Report Based on 2000 Data; MGMA, Englewood, CO.

shows that non hospital based specialists' compensation is higher than hospital-owned practice physicians practicing the same specialty. In terms of gross charges, only nine of the 33 specialties that have comparative data show hospital specialists out-performing their non-hospital based peers. **(For a sample of some specialties, see table, above.)**

Copies of the surveys are available from MGMA by visiting the web site at www.mgma.com or by phoning the association at (303) 799-1111. The cost for physician compensation surveys is \$240 for MGMA member, \$290 for affiliate, and \$450 for others. The management compensation survey costs \$90 for members, \$120 for affiliates, and \$150 for others. ■

Health system ACEs benchmark award

ACE inhibitor program takes annual prize

Ask anyone who keeps data about ACE inhibitor use and they will tell you the numbers should be better. National benchmarking data shows that between 1995 and 1998, use of ACE inhibitors among heart patients was between 30% and 50%, when perhaps as many as 90% of patients should have been on the drug, says **James B. Young, MD**, section head of Heart Failure and Cardiac Transplant Medicine and

medical director of the Cleveland Clinic Health System's Kaufman Center for Heart Failure.

At the clinic's own facilities, 1998 data showed that only 61% of patients who might have benefited from ACE inhibitor use were given the drugs and, according to **Deborah M. Nadzam**, PhD, FAAN, director of the Cleveland Clinic Health System Quality Institute, the range was between 29% and 70% depending which of the eight system hospitals one is talking about.

"We knew it was a problem for us just as it was a problem for others," says Young. "Those of us who have worked in the heart failure arena have tried to improve ACE inhibitor use as a way to impact morbidity and mortality. We had data from our own system and from [the Centers for Medicaid and Medicare Services] that indicated there was underutilization."

Tackling the issue was about more than just impacting patient care though, Young admits. "There were other drug classes that would likely demonstrate benefit, too, and would have a similar lack of utilization. We thought we could create a new paradigm that would work for this drug and others."

Before starting, however, Young and a team of physicians, nurses, and pharmacists looked at what a good target for the health system's patient base would be. "There are a number of national benchmark targets out there that show in a high risk, unstable, hospitalized patient population, the target should be 70 [percent] to 80% of patients on ACE inhibitors," Young explains. "For stable outpatients, it should be 80% to 90%, and for stable patients who can tolerate the drugs without side effects like a rash or cough, you can argue that 100% should be on them."

But in 1998, when they started to look at the numbers, the group wanted to make sure that the target they set was right for its own patient base. "We looked at patients in our hospitals with decompensated congestive heart failure," Young continues. "We looked at comorbidities that might have precluded use. We looked at the actual number of patients we could titrate doses for. And we determined that 80% was a reasonable target."

The team put together a protocol derived from clinical evidence and created teaching tools that clinicians could use, says Young. Among them was a pocket card that would enable physicians to quickly determine the proper dosages for patients. In addition, they created preprinted orders for the physicians and new educational materials for patients. **(See preprinted order sample on p. 141,**

and a sample card, on p. 137.) A new chart review document was created for physicians to document improvement or worsening over time. The program was rolled out via lectures and grand rounds at each individual facility. There was also a continuing medical education dinner meeting for physicians with large numbers of heart failure patients.

"It's not that the docs don't know that ACE inhibitors are good," Young says. "These are hard drugs to use. They can cause rashes, hypotension, odd tastes in patients' mouths, and coughs. It requires time and care to juggle all the other medications a patient might be on and get them titrated on this. So it's not an issue of knowing or not knowing, but of motivating them that the impact they could make is significant enough to offset the hassle factor for the patient. You have to have that buy in." In addition to the main team, says Nadzam, each hospital also formed its own individual team to make sure that the program worked for its individual patient base. "We knew we had to be flexible."

Over the course of 10 months, the system was able to increase the use of ACE inhibitors by 10%. "We didn't reach our target," says Young. "But we were consistent across the system."

The increase was based on data from 3,406 patients discharged with a heart-failure diagnosis. "That's by far our highest-volume DRG," Nadzam adds. Young continues: "In the 10 months of data we used in 1998, there were 17,961 hospital days devoted to caring for heart failure patients. That's why we focus on this."

The system doesn't view the ACE program as finished, he adds. "We aren't there yet, but there are things we have learned over the last two years that make me view the project as a success." For instance, after two years of promoting this program, Young wonders whether 80% is a realistic target for this particular patient population. "When you look at the benchmarks, they are all speculative in nature," he notes. "We are still having a lot of discussions about what would be a realistic target."

Another benefit of the project is its ability to translate to other drug classes. "In the last two years, beta blockers have become perhaps even more important than ACE inhibitors," Young says. "Now we have to work with a drug class that is even more difficult to up-titrate than ACE inhibitors. So we can take this program, look at the beta blockers, and come up with a plan to increase their use using this as a template."

The health system conducted a study that

Continued on p. 138

Source: The Cleveland Clinic Foundation.

showed one-third of patients who could use beta blockers were on them between 1998 and 2000. Currently, that number stands at about 50%. “We think a good target for that might be around 60%, but we haven’t finished figuring it all out yet,” he says. In addition, says Nazdam, the team model used for the ACE inhibitor project has been expanded to other process and quality improvement initiatives. There are now multidisciplinary teams working on stroke care, colorectal and breast cancer care, chronic obstructive pulmonary disease, diabetes, and end care. “It has completely changed the way we do PI and QI.”

Another lesson learned, says Young, is the realization that not every hospital is the same. “When you have a system that has smaller community hospitals, teaching hospitals, and referral hospitals, the patients in these disease categories are all different,” he notes. “The peripheral community hospitals are plagued with elderly patients, often those who are coming from or going to nursing homes. Those aren’t the type of patients who are undergoing heart transplant evaluation at the central referral hospital. Patients are different and diverse. You have to find out how to best manage patients in each institution, and find out what the physicians need to manage that particular population. You have to have a team that understands the differences in patient populations and are flexible enough to make sure protocols differ in ways that make sense to those different populations.”

[For more information, contact:

• **Deborah M. Nadzam, PhD, FAAN, Director, Quality Institute, and James B. Young, M.D., Section Head of Heart Failure and Cardiac Transplant Medicine, Medical Director of the Kaufman Center for Heart Failure, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, OH 44195. Telephone: (216) 444-2270.] ■**

Technology update: Here’s a roundup of newest tools

Hand helds, microfilm, and EMRs make the news

Editor’s Note: Reports of dozens of products and programs are sent to Healthcare Benchmarks every year. Periodically we run down some of the newer and more innovative advances that make gathering, storing, and

using data easier, as well as studies that monitor how you use technology.

For physicians that find hand held computers a boon to their productivity, ePocrates Inc., a San Carlos, CA-based company that provides drug information software to 400,000 users, is linking up with the Institute for Safe Medication Practices (ISMP) and the federal Food and Drug Administration (FDA) to deliver safety alerts and information to users.

More than 165,000 physicians use ePocrates, which provides users with information on some 2,400 drugs, their uses, adverse interactions, side effects, and dosage requirements. The company also offers an antimicrobial reference guide and the new DocAlert messaging system which the ISMP and the FDA programs make use of.

Last March, explains **Lydia Green, RPh**, director of marketing for ePocrates, while attending a conference, she started a conversation with FDA staff who were manning an exhibit booth. “We thought it would be great to send out alerts over our system.”

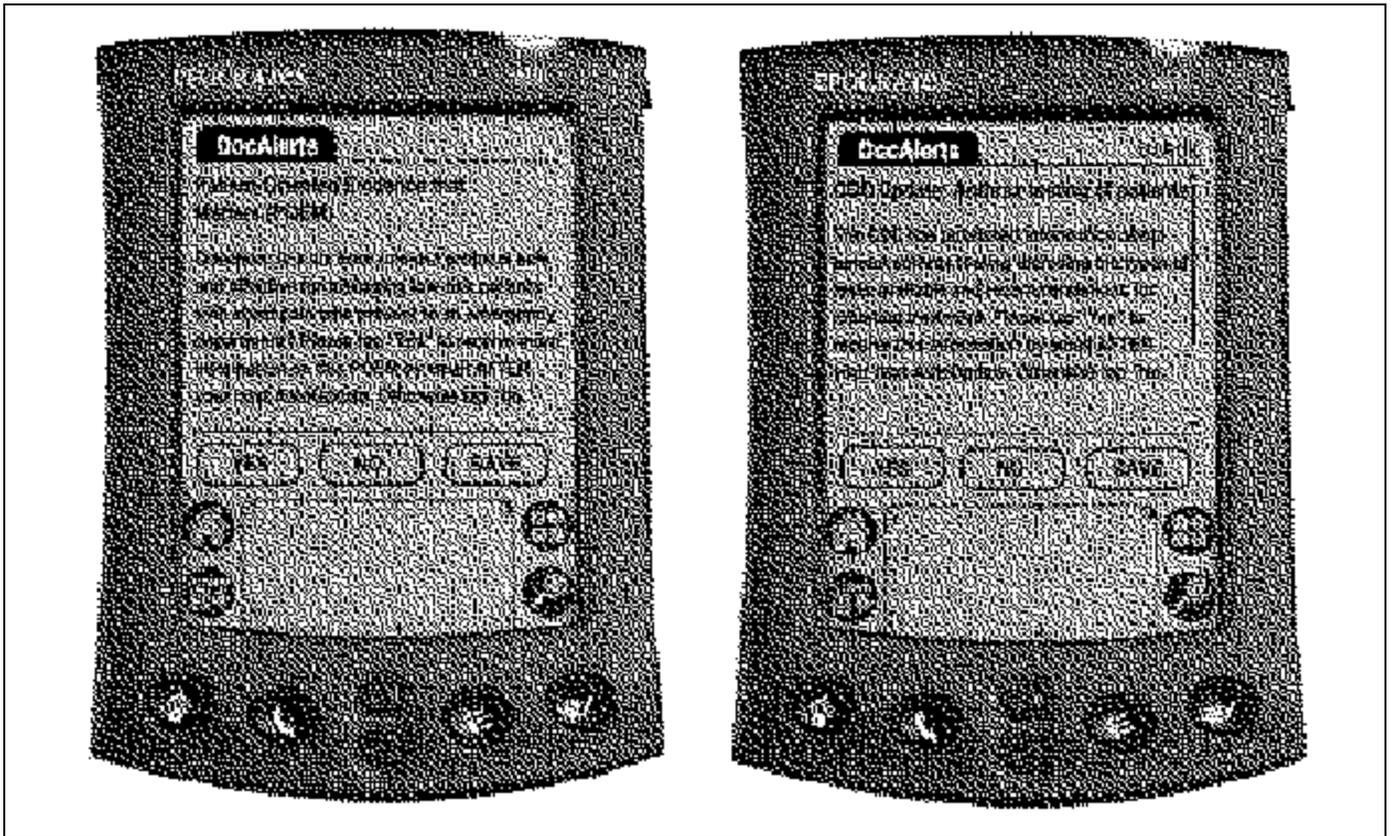
After getting user feedback on what kind of information users might want to see, the program was born. But, says the head of the DocAlert program **Laura Kaufman**, physicians told her they wanted more content. At the same time, the ISMP had written about ePocrates and its products. “They have a newsletter that includes information on sound alike and look alike drugs, as well other features about drug interactions or topical news, like bioterrorism alerts,” says Kaufman.

And so the second partnership was born.

The program sends about two sentences to users and asks if they want more information on a particular topic. **(See sample screens, page 139.)** If they tap yes, when they next plug their hand held device into their PC, users will get an e-mail reply with more information, says Green.

Richard Fiedotin, MD, cofounder of ePocrates and Vice President of Business Development for the company, says they know that physicians are using this information and what kinds of data interests them. “When Baycol [a statin drug manufactured by Bayer] was withdrawn, a lot of doctors read that message. But few wanted more information on that. When we send messages about anthrax or bioterrorism, though, they want more information.”

That provides some insight into what direction the DocAlert program will go. “We get a lot of e-mail from users asking for new features,” Fiedotin



says. “And we survey them and interview users too.”

Kaufman says that in the future, the network may provide information on herbal remedies and treatment guidelines, as well as more “Patient Oriented Evidence that Matters,” or POEM messages, that provides information such as protocols for specific conditions. “We feel we can fill some of the gaps for physicians,” Fiedotin explains. “Physicians don’t learn anything about herbals, for instance, but 70% of patients are using them. Docs need drug interaction information.”

One of ePocrates’ users, **Wayne B. Wheeler**, MD, JD, FACEP, says he uses the DocAlert program daily. “I enjoy the medical questions as mental exercise and occasionally learn an entirely new fact,” says Wheeler, medical director at Community Health and Wellness at Southern Ohio Medical Center, a 300-bed hospital in Portsmouth, OH.

Wheeler says one feature he’d like to see is emergency and occupational board style questions — three or four questions a day with answers and explanations sent with the next update. “Emergency medicine has gone to a continuous readiness for board certification and this would be a useful feature. Many ED physicians have and are transitioning into occupational medicine and need the board questions getting ready for the exam.”

[For more information, contact:

• **Lydia Green**, RPh, Creative Director, Marketing; **Richard Fiedotin**, MD, Vice President of Business Development; and **Laura Kaufman**, Director, DocAlert, ePocrates Inc., 120 Industrial Blvd., San Carlos, CA 94070. Telephone: (650) 232-4803.

• **Wayne B. Wheeler**, MD, JD, FACEP, Southern Ohio Medical Center, 1507 27th St., Portsmouth, OH 45662. Telephone: (740) 356-6193.] ■

New data storage system saves \$20,000 per year

Mercy Medical Center – North Iowa in Mason City, IA, used to spend a lot of time and money putting reports and data on paper and microfilm for storage and future use. Indeed, until very recently, reports generated by the hospital’s Med Series IV information systems, Shared Medical Systems billing software, and Sunquest lab management computer systems generated paper reports for dissemination to those who needed copies. Many of the reports, such as patient bills and lab results then had to be archived on microfilm and microfiche. The hospital paid a fee of about \$20,000 per year for copying, and more

money still in storage pace, says Maggie Herman, a systems analyst at the hospital. "We were always looking for places to store all this information that we're required to keep," she notes.

Now, a new computer output to laser disk (COLD) system has replaced the old ways, and the hospital expects to save not only the \$20,000 in copying fees, but an additional \$80,000 annually, as well. The system captures internal reports generated by the hospital information and laboratory management systems and downloads them to a hard drive. This information is accessed from PCs rather than being distributed on paper. The system is also replacing microfilm and microfiche as the permanent repository for documents that must be stored. A new imaging system that will be added to the system later this year will capture digital representations of paper documents such as patient charts and personnel records and store the images in the COLD database. By eliminating the microfilming costs for these documents, the imaging system will pay for itself in the first year of operation.

Additional benefits

There are other benefits to the new system, developed by Metafile Inc., of Rochester, MN. Because the old reports were hand delivered, there was often a delay between when a report was generated and when it reached recipients. In addition, says Herman, it was difficult to find information in stored documents.

The storage facility wasn't in the main part of the hospital and searching among paper documents for the specific report was difficult. "One of our lab clerks had to go through 900 pages of documents at the end of every month and look for two specific charge numbers," she says. Data security was compromised by fact that both microfiche and microfilm documents could be damaged and misfiled.

Finally, this archival method affected service. When a patient or an insurance company needed a copy of a bill that had been purged from the computer and stored on microfilm, it wasn't possible to respond to the request immediately.

These issues led the hospital to search for technology that would "let us get away from paper as much as possible," according to Herman. A team of individuals from various departments led by Herman researched the technology and learned that a COLD system would address many of the limitations of the current approach by reading the report files generated on the AS/400 and RS/

6000 computers and distributing them over a network. It could also serve as the archival mechanism, storing the information in digital format and eliminating the need for microfilm and microfiche. An imaging system would complement the COLD system by making it possible to scan and digitally archive documents such as patient charts and employment applications that must be created in hardcopy format.

Herman's team evaluated four vendors' systems before choosing Metafile. One of the main reasons for the choice was that Metafile's COLD and imaging systems shared the same database. "Some of the other vendors' programs weren't so tightly linked, and if you wanted to search for something, you'd have to search the COLD database and the imaging database separately," Herman explains. Metafile's programs also seemed to be the most user friendly. They also met other selection criteria including a full text search capability, ability to work with multiple systems (such as Sunquest Lab and Med Series IV), support for different levels of security, ability to use over a wide area network, and support for a variety of storage media including hard drive, CD-ROM, and DVD-RAM.

Since installing the COLD system, Mercy has stopped printing many of the day-end and month-end processing reports and distributing them manually. The COLD system reads the files created by the information and laboratory management systems and converts them to compact, searchable files. The software automatically scans a specified location for the files, and if they are found, automatically downloads them to a Windows NT server. The information is available to hospital employees at their desktop PCs. They no longer wait for reports to be printed and distributed but can access the information almost as soon as it is created.

Eliminating storage concerns

Reports are currently stored on a hard drive, but the hospital is eventually going to install a DVD tower to serve as the permanent storage medium. By using the COLD system and a digital archival method, the hospital has eliminated \$20,000 of its annual microfiche and microfilm costs. Now the continual search for storage space is no longer a concern. Perhaps more importantly, access to stored information is almost immediate. Rather than getting up from a desk and going to a distant storage site, a user simply performs a search with MetaViewer from

Source: The Cleveland Clinic Foundation.

his desk. The system's full text search capability makes it possible to search for a specific number or name anywhere in a document. The clerk who used to spend hours searching through 900 pages now finds the charge numbers she needs in minutes. By providing this kind of convenience to hospital employees, the COLD system is also benefiting patients, doctors, and insurance companies. When one of them has a question about a past bill, for instance, Patient Accounts employees can find the information through their PCs and respond instantly. This eliminates the time they used to spend taking down the necessary details, going to the archives to find the relevant information, and calling the person back later with the answer.

The COLD system is also being used to backup the laboratory information management system (LIMS). It makes it possible to determine patient blood types and groups when the LIMS is down. The laboratory also uses the cold system to produce reports required to comply with regulatory agencies. The hospital is currently in the process of setting up access to Metafile in remote clinics via its wide area network.

Currently Mercy Medical Center - North Iowa sends via courier or faxes copies of monthly reports to approximately 40 clinic sites all across North Iowa. These clinics will soon view their monthly reports with MetaViewer resulting in easier and timelier access to the reports.

Mercy will also soon install a Metafile imaging system to digitally capture hard copy documents created by the medical records, human resources, and education departments. This will add 100 more users to the 30 who currently access the Metafile database. When the imaging system is implemented, the hospital will no longer need to make microfilm or microfiche copies of patient charts, personnel records, and competency reviews. These and other HR and Education Department documents currently account for \$80,000 in microfilming costs annually. By avoiding that expense, the hospital will recoup the costs of the imaging software, the scanner, and the DVD storage in one year.

[For more information, contact:

• **Maggie Herman**, Systems Analyst, Mercy Medical Center - North Iowa, 800 Mercy Drive, Council Bluff, IA. Telephone: (402) 572-2077.

• **Metafile Information Systems Inc.**, 2900 43rd St. NW, Rochester, MN 55901. Telephone: (507) 286-9232.] ■

EMRs are seen as operating efficiency

Pundits have always been quick to label the health care industry as slow to adopt new technologies and physicians in particular as averse to change. But a new survey by the Medical Group Management Association (MGMA) Center for Research in Englewood, CO and Pfizer Health Solutions found that — at least when it comes to using electronic medical records (EMRs) — that's not true at all.

Some 593 respondents to the survey provided information on their use of EMRs, what they saw as barriers to implementation, and what they viewed as some of the benefits. According to MGMA president and CEO **William Jessee**, MD, CMPE, health care isn't as afraid as it is often portrayed to be. "These results show an exciting paradigm shift in the health care industry. It is realizing the importance of technology and is embracing it to improve productivity and patient satisfaction."

Among the survey results:

- 21.6% of health care organizations have already implemented an EMR system, and most of the rest (67.9%) are considering it. Growth in business is one of the reasons spurring this adoption. According to the survey, many groups view EMRs as a way to improve efficiency and quality of care delivery.

- 91.4% of respondents believe that computer automation in general can help address some or all of a list of 19 problems they commonly face — the most serious of which are insurance bureaucracy and reimbursement rates. Others on the list include increasing workloads, regulatory and HIPAA compliance, and availability and completeness of patient charts. Just over four-fifths of respondents believe that implementation of an EMR can specifically help address the problems they identified.

- 29.6% say that since they implemented EMRs they have more free time after hours.

- 50.4% of the respondents report increased provider satisfaction, and 31% say that since they implemented the EMR, patient satisfaction has also increased.

- Among those who have not yet implemented EMRs (464 respondents), 14% say they will do so in the next six months, 16.4% in six to 12 months, and 31.7% in 13 to 24 months.

The survey also asked the 128 respondents who use EMRs what makes for a successful implementation. Almost all (80.5%) reported that getting

active staff involvement was vital. Other key elements of implementing such a program include active leadership and provider involvement, and making sure vendors provide on-site training.

Among the biggest barriers to implementation, respondents said that the number one obstacle was a lack of resources to invest in information technology. Other issues included the time and effort it takes to prepare the organization for an EMR system, difficulty integrating systems, difficulty establishing a good return on investment, and a lack of provider support. The complete survey can be viewed at <http://ftp.mgma.com/pub/WEB-MISC/EMR-study/EMR-report.pdf>. ■

Hospital financials show improvement in early 2001

Margins are up, says Solucient study

The first two quarters of 2001 were better to hospitals than previous periods, according to a study released by the health care consulting firm Solucient. *The Health of Our Nation's Hospitals: Mid-Year Update*, released in early November by the Evanston, IL-based company, reports that operating margins at the nation's hospitals increased from 4.2% during the first half of 2000 to 5.2% during the same period this year.

Comprised of operational data from a wide array of nonprofit hospitals, major hospital systems and academic medical centers, Solucient's data indicate that hospital operating margins still fall short of levels from before the Balanced Budget Act of 1997. The report continues: "Other factors that may contribute to this continuing lag include the release of adjusted Medicare payments rates in the Fall of 1999, as well as the implementation of the Health Care Financing Administration's [now the Centers for Medicare and Medicaid Services; CMS] outpatient prospective payment system."

On a positive note, the study reports that first quarter 2001 operating margins are the highest since 1998, and there are other signs that the complete year figures for 2001 may be an improvement over last year. For instance, although there are seasonal patterns which indicate that the second half margins will be lower than the first half, the difference between quarter one and quarter two margins is lower this year than in the past, suggesting that 2001's annual average margin

will be higher than last year.

The margins do differ depending on hospital characteristics. Smaller facilities with fewer than 150 beds have higher margins than their counterparts with more than 300 beds. Medium-sized hospitals are feeling the pressure of lower reimbursement levels, but have made up for it by focusing on more profitable service lines.

One of those profitable service lines is cardiology, and another study released simultaneously by Solucient shows that the demand for cardiology services is destined to increase over the next

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Editor: **Lisa Hubbell**, (425) 739-4625.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).

Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).

Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).

Production Editor: **Emily Palmer**.

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Editorial Questions

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several years. The study reports that demand for cardiology services is due to increase 44% more than the average of other service lines — 8.8% vs. 6.1% average — between now and 2006. Other service lines that many struggling hospitals find less profitable are nearly stagnant. For example, obstetrics is expected to increase by only 0.4%.

In the hospital report, Solucient also reported a regional difference in margins. Hospitals in the Northeast show the greatest improvement, with a mid-year 2001 operating margin of 6.96%, compared to a 2000 year-end margin of just under 5%. The South Central region continues to lag behind the rest of the country at a low level of 2.05%.

According to Solucient's report, despite the better news, there is still a question about the industry's sustainability. Health care costs are increasing at more than 7%, according to industry reports, the study notes. But since margins remain low, there is still long term financial risk for hospitals. The report continues: "[M]argins are well below a financially sustainable, healthy operating level, and are still below the industry margins prior to 1997. So, while there may be some indication of recovery, the seasonal shift in which fiscal performance traditionally diminishes after the first two quarters makes it premature to declare an industry-wide upturn." ■



JCAHO launches disease specific care certification

Come February, hospitals, health systems, and other health care organizations can become certified for disease-specific care by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the development of its new Disease-Specific Care Certification Program.

The program will certify providers of comprehensive services for patients with chronic illnesses based on an assessment of compliance with consensus national standards, the demonstrated effective use of established clinical guidelines to manage and optimize care, and the measurement and improvement of health outcomes. More information is available at the JCAHO web site, www.jcaho.org. ■

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NCQA to announce more HEDIS software vendors

If you're in the market for new Health Plan Employer Data and Information Set-related software, check out the National Committee for Quality Assurance (NCQA) web site (www.ncqa.org). The Washington, DC-based organization is due to announce certification in December of 10 more vendors who completed the certification process.

To validate vendors' software, NCQA generates unique sets of sample data, or "test cases," that vendors process using their HEDIS software. NCQA then compares the vendor's output to the expected results to determine if the software computes HEDIS results correctly.

A vendor's software receives a final "pass/fail" status for each coded measure. The certification process is voluntary, and successful completion satisfies the source code review component of the audit required as part of the NCQA Accreditation process.

All five vendors that received certification in 2000 are participating again in the program. In addition, five vendors are participating for the first time.

The vendors are: AdvanceMed Corp., Catalyst Technologies, Elytix, LLC, Ingenix Inc., McKesson LLC, The MEDSTAT Group Inc., OAO HealthCare Solutions, Qmark/HEDISHelp, Vector Research Inc., and ViPS Inc. ■

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