# Surviving the Storm

## Tumultuous Times for America's Small Community Hospitals

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# Surviving the Storm

## Tumultuous Times for America's Small Community Hospitals, Chapter 1

Susan Carol Associates Public Relations, Inc. (SCAPR), Fredericksburg, VA, recently completed a market study to determine the top areas of concern for today's small community hospitals. Funded by Siemens Financial Services, Inc. (SFS), SCAPR's research found six major areas of concern for community hospital leaders: the federal mandate of electronic health records (EHR), access to capital, payor mix (dominated by Medicaid/ Medicare), technology upgrades, nurse shortages, and physician recruitment.

In Chapter 1, SCAPR presents two of the six concerns: EHR and access to capital. SCAPR will present the remaining challenges facing small community hospitals in Chapters 2 and 3.

## Challenge: Meeting Federally Mandated EHR

Among the top challenges faced by small community hospitals is the federal mandate requiring use of electronic health records (EHR) technology by 2014. Hospitals not meeting the mandate are expected to experience decreases in Medicare reimbursements starting in 2015.

As an incentive to hospitals and other care providers, the federal government has committed $19 billion in funding through the American Recovery and Reinvestment Act (ARRA) of 2009. Yet, these funds will be awarded only to those hospitals and other providers that can demonstrate they have achieved "meaningful use." The definition proposed for meaningful use contains specific measures and criteria that hospitals will be required to meet each year from 2011 through 2015. However, of most concern to numerous community hospitals now is the measure requiring that 10% of all physician orders in 2011 and 2012 be entered using Computerized Physician Order Entry (CPOE).

Ironically, lack of capital to purchase this technology—and others related to EHR in the next five years—will likely prevent these facilities from qualifying for incentive funds that would provide them with desperately needed reimbursement. As of March 2009, just 1.5% of more than 3,000 hospitals surveyed had comprehensive EHR systems in place[1], and less than 8% had even partial systems that enable physician and nurse notation.

Still other requirements that add specific disclosure-accounting duties to EHR use will further increase its cost. A 2009 analysis performed by PricewaterhouseCoopers showed that stimulus incentives to comply with EHR requirements do not come near to compensating hospitals' overall costs. Yet, 50 of 100 chief information officers (CIOs)[2] surveyed earlier by PricewaterhouseCoopers said federal funding is "crucial" to their ability to implement EHRs.

# SCAPR's In-Depth Report:
# The McDowell Hospital

Located in Marion, NC, The McDowell Hospital is a non-profit facility licensed for 65 beds, but staffed for 49. Average census runs about 20 beds. The hospital is considered a "tweener" facility because it is too large to qualify for federal assistance as a critical-access hospital, and too small to afford the physicians it needs and the EHR technology that will soon be required.

The century old establishment operates a cardiopulmonary department with a two-bed sleep laboratory and an accredited echo and stress lab. Included in the 37-bed Medical/Surgical Unit is an outpatient infusion service for chemotherapy, blood transfusion, and other infusion therapies. With more than 35,000 procedures performed annually in its imaging department, the hospital offers nuclear medicine, MRI, CT scanning, mammography, and ultrasound. An ancillary rural health clinic provides non-emergent care. Payor mix is 16% Medicaid, 39% Medicare, and 12% no-pay.

To stem mounting deficits, in 2004, the hospital joined Mission Health System, a five-entity consortium that has as its largest member Mission Hospital, an 800-bed facility in Ashland, NC. "I think the days of the independent, not-for-profit hospital are coming to an end," said McDowell CEO Edward Hannon.

The merger notwithstanding, Hannon says capital spending at McDowell for the last three years is roughly 50% of the previous rate. A project to install a full PACS facility has been delayed indefinitely, and plans for attaining EHR functionality have not yet been made.

"Our parent hospital has a different information system than we do, and they're way down the road on electronic medical records," said Hannon. But leadership at McDowell is working to decide whether the hospital should invest several million dollars to convert to the information system used by Mission Hospital—or choose a somewhat less expensive system that would still cost $2 million, but require integration with Mission's system, a process that itself could create new technology challenges.

Regardless of which system is chosen, McDowell will receive financial assistance for the project from its parent. Without this infusion, Hannon says the facility would be unable to afford any type of EHR technology. During the last three years, McDowell has used operations to fund capital projects to the level of the facility's depreciation. No loans are outstanding, and with continuing financial assistance from Mission Health System, Hannon is determined to incur no new debt. It is likely, then, that capital projects already delayed will be delayed further. Prospects for a capital campaign that would provide a modicum of relief are nonexistent, Hannon says, because with local unemployment hovering near 15%, the community cannot afford it.

**Facility:**
The McDowell Hospital, Marion, NC

**Situation:**
- Too large to qualify for federal assistance; too small to afford physicians & EHR technology
- Local unemployment at 15%; community cannot support a capital campaign

> "I think the days of the independent, not-for-profit hospital are coming to an end."
>
> Edward Hannon, CEO,
> The McDowell Hospital

[1] *New England Journal of Medicine,* March 25, 2009
[2] *Rock and a Hard Place,* PricewaterhouseCoopers Health Research Institute, April, 2009

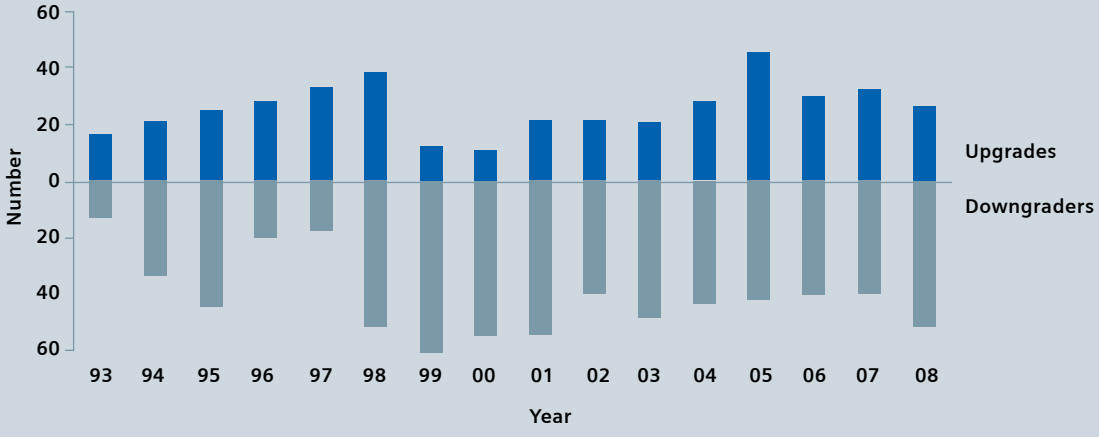
# Challenge:
# Accessing Capital

Many small community hospitals are governed by boards of directors that are opposed to incurring debt. Yet, mounting deficits are forcing these institutions to seek financial support from commercial sources, capital campaigns or affiliations with larger hospitals – or to consider closing their doors.

One small community hospital in Virginia carries approximately $25 million in long-term debt in the form of bonds. Its CEO said, "We have always operated on the philosophy of borrowing as little as possible," but have found it necessary to borrow to execute expansion projects, such as a recent two-floor addition that added 40 private patient rooms.

A dramatic difference exists between small community hospitals that choose to avoid taking on debt, and those that, due to damaged credit ratings, no longer qualify for financing. One 2009 report found that 44% of hospitals surveyed by the American Hospital Association in 2008 classified capital from banks and financial services companies as "significantly harder to access" today than in previous years[3]. The same report found that 45% of these hospitals were also experiencing more difficulty than before obtaining tax-exempt bonds. Although the study did not break out figures for small community hospitals, it is realistic to believe that, due to these facilities' payor mixes and rural environments, access to capital for these hospitals is equally as difficult or more so.

**Number of Bond Rating Upgrades and Downgrades, Not-for-Profit Healthcare, 1993-2008**
Over this 15-year period, the number of bond rating downgrades at not-for-profit healthcare facilities occurred much more frequently than upgrades.




Source: Moody's US Public Finance, *Moody's Not-for-Profit Healthcare 2008 Year-End Ratings Monitor*.
Data released January 2009.
(1) Includes stand-alone hospitals, health systems, and human service providers
Reprinted with permission, American Hospital Association

# SCAPR's In-Depth Report:
# Clark Regional Medical Center

Licensed for 100 beds and staffed for 50 acute and 25 skilled beds, Clark Regional Medical Center is situated 15 miles east of Lexington, KY, and serves a population of 60,000. Services include an 8-bed ICU, cardiac and pulmonary rehabilitation, a sleep disorder center, and a breast imaging center, which is one of six in the state recognized for excellence by the American Radiology Association. The facility has operated as an independent, non-profit organization since its inception in 1915, but Robert Fraraccio, CEO, believes that economic and industry pressures make affiliation with a larger partner both a necessary as well as an attractive option.

Reimbursement rates for patients insured by Medicaid and Medicare, who together compose 53% of patient load, run at about 50% of charges. A significant increase in charity care and bad debt over the past 18 months has begun to erode hospital margins.

Three years ago, the hospital was able to finance a new, $7 million IT system with bonds, issued, at what Fraraccio said, was a "good rate." Today, however, "access to capital markets is more of a challenge due to the economy and stricter criteria on the part of the rating agencies," said Fraraccio. Although Clark Regional needs to replace its 42-year-old main building, bond financing is not being considered as an option. Instead, hospital leadership is searching for a financial partner. "We're in a strong financial position now, and this is a good time to be looking for a partner," Fraraccio said.

Excluding the IT system, Clark Regional has been able to fund other capital expenditures, such as an $850,000 CT scanner and a $600,000 digital mammography unit, through operations. When the bonds are paid off in fiscal 2010, Fraraccio said the hospital will use operating funds to stay current with medical technology. Repaving parking lots and upgrading existing structures will be secondary priorities.

"We're looking to [partner with] a health system that will enable us to have a new hospital in our community and can also provide the benefits of group purchasing and contract reimbursement at a better rate," said Fraraccio. "We feel good about the prospects."

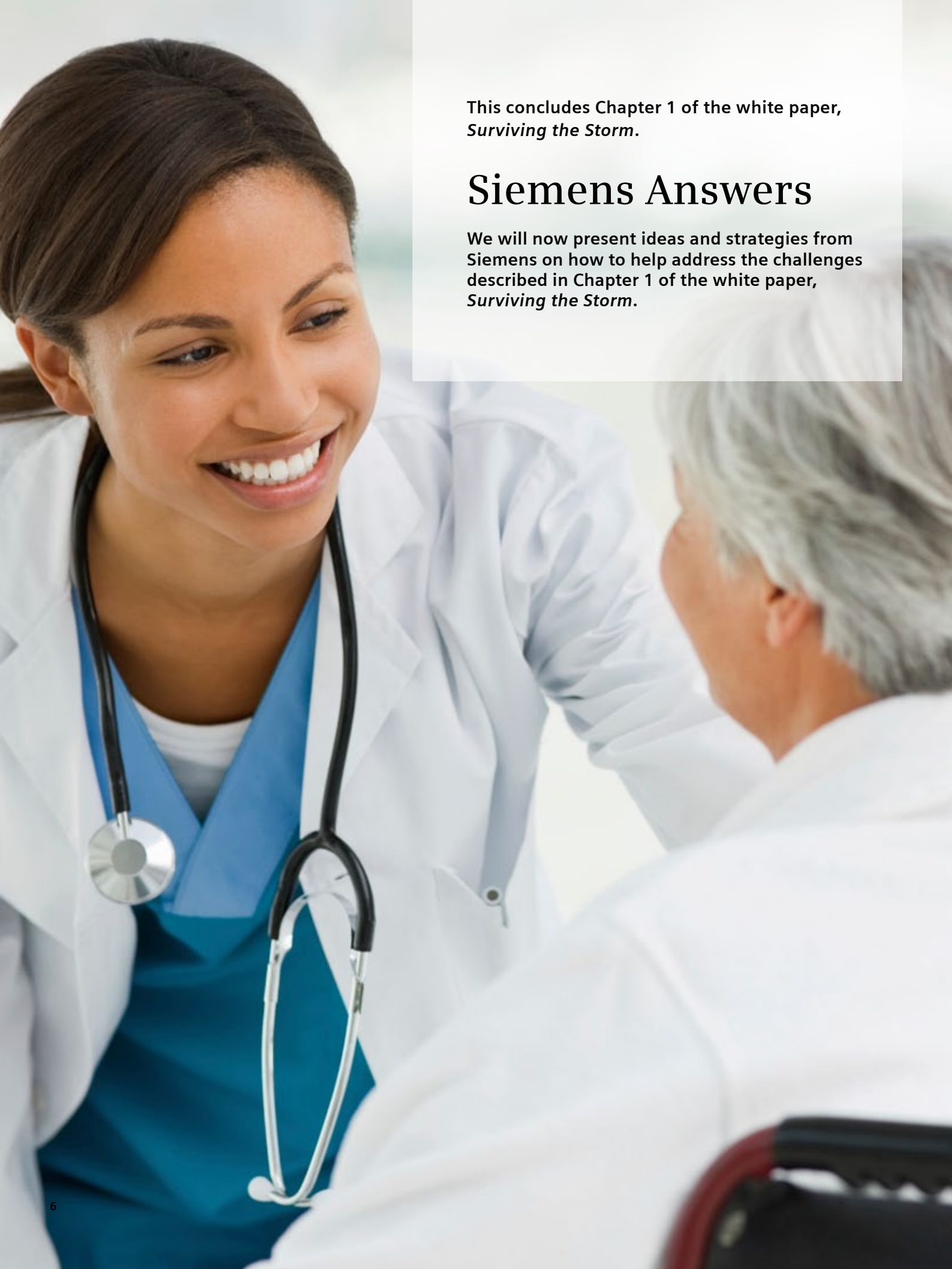
**Facility:**
Clark Regional Medical Center, Winchester, KY

**Situation:**
- A significant increase in charity care and bad debt over the past 18 months eroding hospital margins
- Bond financing no longer an option

"Access to capital is a challenge. ...This is a good time to be looking for a partner."

Robert Fraraccio, CEO,
Clark Regional Medical Center

[3] The Advisory Board Company, "Reprioritizing Capital Investments: Deploying Capital in an Era of Tight Credit," April, 2009



**This concludes Chapter 1 of the white paper, *Surviving the Storm*.**

# Siemens Answers

**We will now present ideas and strategies from Siemens on how to help address the challenges described in Chapter 1 of the white paper, *Surviving the Storm*.**

# Solution: Flexible, Affordable EHR

As the number of projects that require attention grows, you are challenged with balancing government regulations and incentives with what is affordable and reasonable for your facility to achieve. To qualify for the government incentives for community hospitals, you need to:

- be using a certified electronic health record;
- be a "meaningful user" of EHR;
- provide for the electronic exchange of health information;
- be able to report on clinical quality measures.

Siemens Healthcare MedSeries4® is a comprehensive HIS solution designed specifically for the unique challenges of the community hospital. Its affordability, flexibility, and easy-to-use interface can help you meet some of your most mission-critical goals, including improving patient care, attracting and retaining staff, and growing revenues or reducing operating expenses—all while drawing you one step closer to EHR.

Depending on your current level of HIS implementation, MedSeries4 offers a full suite of CCHIT Certified® inpatient applications needed to execute an EHR solution at your facility.

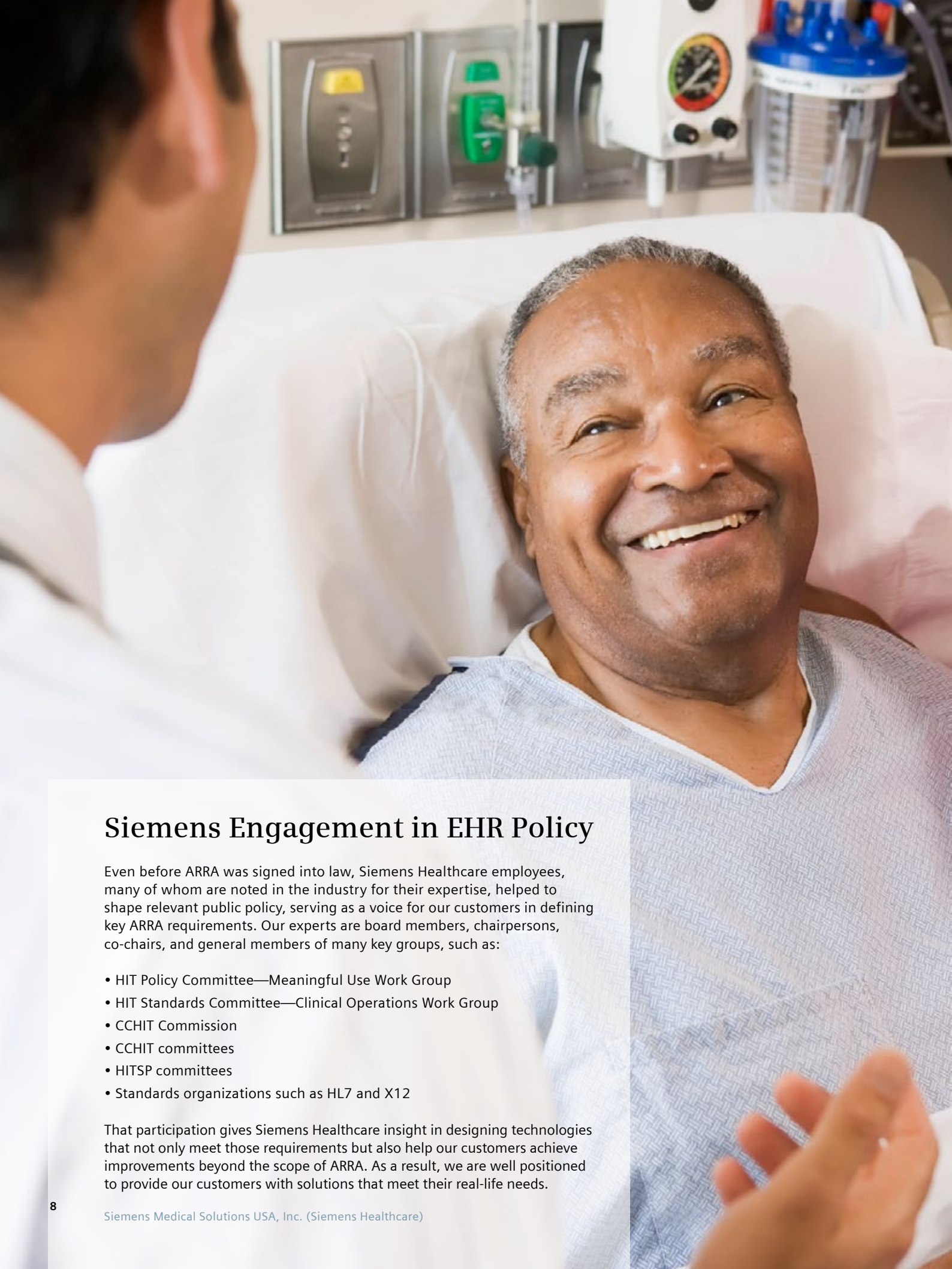
Further, MedSeries4 can be delivered as an ASP offering. By having us remotely host the solution out of our Information System Center, MedSeries4 can help your community hospital minimize capital expenditures as well as the amount of IT staff needed to maintain the solution. You can feel confident that your data is protected and your system stays current.

MedSeries4's Clinical Suite solution is known for its intuitive, easy-to-use user interface. With three clicks or less to get to vital clinical data, information is at your fingertips; access is as simple as accessing the Internet. This access to information allows nurses to be more efficient and reduce the time needed for paperwork while increasing the time spent with patients. Since caring for patients, not doing paperwork, is why nurses become nurses, this adds to overall staff satisfaction.

With MedSeries4, physicians also have access to comprehensive patient information and the necessary tools to direct, manage, and document patient care. Tailoring options like patient summary view, order sets, and inbox capabilities allows data to be presented the way physicians want it presented—in a format that is conducive to how they practice medicine.

**To learn more about our MedSeries4 solutions, visit www.usa.siemens.com/ms4solves.**

| Need | Applications |
|---|---|
| **Certified Core EHR** | MedSeries4® with Siemens Healthcare Pharmacy and Med Administration Check™, Version 28.10 and V24 respectively, is a CCHIT Certified Inpatient EHR (eMAR ONLY) product for 2007 |
| **Meaningful Use** | Meeting the requirements for ARRA-HITECH Meaningful Use monies with MedSeries4<br>• Quality Reporting Tools<br>• CPOE Adoption<br>• Interoperability with CCD for electronic copy of Patient Health Information |
| **Proactive Revenue Cycle – Drives reimbursement performance** | MedSeries4 with HDX Eligibility tools and Siemens Healthcare EDM/HIM solution |
| **Paperless Hospital Solution** | Return on investment with Siemens Healthcare EDM/HIM solution, reducing costs associated with production and storage of paper and creating a greener environment |
| **Ancillary Solutions** | Open architecture to any lab or radiology system (Siemens NOVIUS® Lab and *syngo*® Radiology) |



# Siemens Engagement in EHR Policy

Even before ARRA was signed into law, Siemens Healthcare employees, many of whom are noted in the industry for their expertise, helped to shape relevant public policy, serving as a voice for our customers in defining key ARRA requirements. Our experts are board members, chairpersons, co-chairs, and general members of many key groups, such as:

- HIT Policy Committee—Meaningful Use Work Group
- HIT Standards Committee—Clinical Operations Work Group
- CCHIT Commission
- CCHIT committees
- HITSP committees
- Standards organizations such as HL7 and X12

That participation gives Siemens Healthcare insight in designing technologies that not only meet those requirements but also help our customers achieve improvements beyond the scope of ARRA. As a result, we are well positioned to provide our customers with solutions that meet their real-life needs.

# Solution: Financing for EHR and Beyond

Siemens Financial Solutions, Inc. can provide financing for the initial capital requirements to implement an EHR system, such as perpetual software licenses, professional services, and computer hardware. We can provide progress pay (construction) type financing during the implementation phase of the project where advances are requested to pay vendors as work is completed. Once the implementation is complete, we can provide a term loan and work with you to structure its repayment to more closely match the receipt of EHR government incentives.

With an intimate knowledge of Siemens Healthcare's market-leading technology, Siemens Financial Services, Inc. is uniquely positioned to understand your challenges. Our employees have a deep knowledge of not only the financial aspects of healthcare but also of healthcare delivery. This unique perspective allows us to work with you on a team level, providing integrated clinical and financial solutions that enhance staff productivity and patient care while optimizing your financial outcomes.

Now more than ever a delicate balance must be struck between meeting current needs and preparing for the future. It's understandable why CFOs and CEOs are reducing expenses and trying to preserve available cash and credit lines. Deciding where and when available capital resources should be used could mean the difference between short-term viability and long-term prosperity.

The good news is once a capital project has been deemed worthy of pursuing, the concern over access to capital can be addressed by seeking financing from Siemens Financial Services, Inc. We have more than 20 years of lending experience in the healthcare market. Let us help you realize the strategic goals for your hospital.

**Siemens Financial Services, Inc. offers:**

- **Equipment leasing**
- **Tax-exempt financing**
- **IT project financing**
- **Construction and real estate financing**

To learn more about financing, visit **www.usa.siemens.com/healthcarefinance.**


# Surviving the Storm

## Tumultuous Times for America's Small Community Hospitals, Chapter 2

In Chapter 1, SCAPR covered EHR and access to capital. Here, in Chapter 2 of the series, SCAPR presents two more concerns: payor mix and technology upgrades. The remaining two challenges will be presented in Chapter 3.

## Challenge: Payor Mix Dominated by Medicaid/Medicare

A payor mix dominated by Medicaid and Medicare ranks as the largest challenge for small community hospitals. Often operating in rural areas made poor by lack of economic development or recent factory closures, these facilities serve a disproportionate number of patients who are unemployed or perform hourly work at firms that pay low wages and do not provide health insurance. As a result, small community hospitals look to government reimbursement programs for as much as 70% of their income. Yet, reimbursement rates for these hospitals typically range from a high of roughly 75% of charges billed to a low of 0%, creating chronic deficits that cannot be easily or quickly overcome. In the words of one community hospital administrator, "Charges don't really mean much. The reality is half of what you charge is what you see."

Compounding the problem is a growing percentage of "self-pay" accounts. SCAPR found that at small hospitals, particularly rural establishments, self-pay is often a euphemism for no-pay. Nonprofit hospitals are required by the Internal Revenue Service to deliver an amount of charity care commensurate with the value of their tax exemptions. But when these amounts are exceeded, hospitals suffer—particularly small community facilities lacking the capital to purchase technology, equipment, and personnel that could be employed to provide new, lucrative services. According to a survey conducted by the Healthcare Financial Management Association, increases in charity care had a negative financial impact on 62% of 309 hospitals of all sizes that were surveyed in 2008, while increases in bad debt affected 63% negatively.

# SCAPR's In-Depth Report:
# St. Claire Regional Medical Center

Mark Neff, CEO of St. Claire Regional Medical Center, sees payor mix as one of the facility's most important issues. In 2008, Medicaid reimbursements fell $1.1 million short of the actual cost for Medicaid patients. Medicare reimbursements for the same year fell $2.9 million short of costs for Medicare patients, bringing the total reimbursement shortfall for both programs to $4 million. Charity care for patients who have no healthcare coverage and cannot afford to pay for services cost St. Claire Regional an additional $4.6 million in 2008—a 44% increase over 2007[2]. Thus, in 2008, unreimbursed care at St. Claire Regional cost $8.6 million.

"Last year was really tough in terms of overall financial results, so we contracted substantially on capital spending," said Neff. St. Claire Regional typically spends roughly $5 million per year on capital projects, including renovations, strategic issues, and equipment replacement. But now, several renovation projects of $100,000 or less have been delayed indefinitely, and the replacement schedule for certain types of equipment not affecting the quality of patient care has been slowed.

St. Claire Regional borrows capital periodically. It financed a major construction project in 1994 with bonds and a smaller medical equipment acquisition (CT and PACS) about three years ago for $5 million in bonds, which were issued through Rowan County, KY, and purchased by a local bank. Neff said looming electronic health record (EHR) requirements may prompt another bond issuance of roughly $5 million. "We're talking with a group of community and regional banks about purchasing these," Neff said. Since St. Claire Regional is one of the stronger financial customers in the area and local banks are searching for loan customers, he added, he expects interest rates to be "fairly reasonable."

Meanwhile, St. Claire Regional is adding services to increase revenues. A hyperbaric wound chamber was purchased last year at roughly the same time the hospital's medical equipment delivery and home rental service moved from the hospital to an 8,000-sq.-ft. retail location. "It's early," says Neff, "but both of these projects are growing each month." The hospital's latest service development: the addition of angioplasty, stents, and other interventional services to its cardiology capabilities.

**Facility:**
St. Claire Regional Medical Center, Morehead, KY

**Situation:**
- Medicare/Medicaid reimbursements $4 million short
- More than 44% increase in charity care

"Last year was really tough in terms of overall financial results, so we contracted substantially on capital spending."

Mark Neff, Chief Executive Officer
St. Claire Regional

[1] "The Financial Health of U.S. Hospitals and Healthcare Systems," Healthcare Financial Management Association, January, 2009

[2] St. Claire Regional Medical Center, *2008 Community Benefits Report*

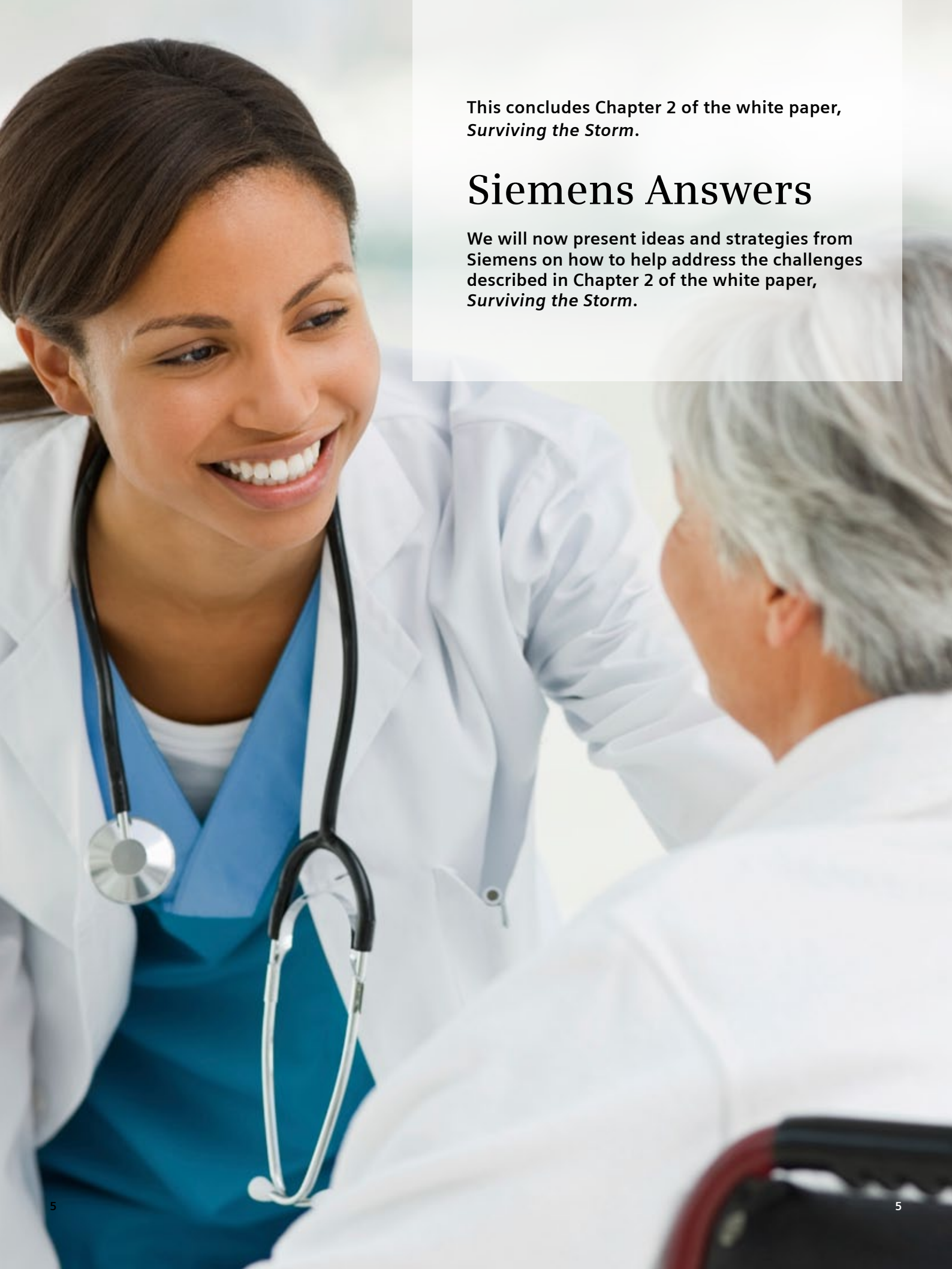
# Challenge: Upgrading Technology

SCAPR found that many small community hospitals try to pay for technology upgrades from their operating funds. But this practice is becoming much more difficult as certain technologies, such as IT, advance in complexity and cost. For one small rural hospital, 2008 was particularly challenging, due in part to the purchase, from operating funds, of a $16-million IT upgrade that completely revamped clinical and financial systems. The upgrade will allow the facility to install CPOE for use by physicians in the hospital and at physician practices miles away. "Not many small hospitals have the money, talent, and resources to implement this type of IT," said one hospital CEO. "It's expensive and it's hard to get your arms around the return on investment." The new system is enhancing patient safety and care, but financially, he said, "It's a black hole."

To keep debt to a minimum, many small community hospitals have deferred building renovations and cosmetic upgrades and postponed the replacement of CT scanners, mammography machines, and MRI units. "You have to be really efficient and smart about what you do," said one CEO, "because you can't cover a lot of your mistakes with revenue."

Yet, deferring the purchase of new technology can be a double-edged sword. Small hospitals may preserve capital by continuing to use older equipment, but a percentage of patients are likely to move their care to other facilities using the latest technology and medical devices. Uvalde Memorial Hospital's James Buckner says stroke response is impeded at Uvalde Memorial because Medicare does not yet reimburse appropriately for telemedicine. Without telemedicine, "we can't get our patients thrombolyzed in time to compete with stroke specialty centers," he said.

State medical boards can also impede small hospitals' acquisition of new technology by increasing certification requirements for certain procedures. In Texas, Uvalde said, the state medical board is working to require that a physician assistant or nurse practitioner be present during telemedical procedures to present the patient to the camera and converse with physicians making the diagnosis. Currently in Texas, an LPN or a medical assistant is required for this role.



**This concludes Chapter 2 of the white paper, *Surviving the Storm*.**

# Siemens Answers

**We will now present ideas and strategies from Siemens on how to help address the challenges described in Chapter 2 of the white paper, *Surviving the Storm*.**



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# Solution: Expand Services & Revenue with Tax-Exempt Financing

Investing in technology can be a significant portion of your hospital's planned capital spending. Most hospitals like yours invest in technology because they expect it to help improve patient outcomes, patient safety, and physician/nursing recruitment and retention, while it drives down expenses and raises revenues.

But where do you get the capital? Typically, the funding for the majority of these capital projects comes from the issuance of tax-exempt bonds. However, access to the bond market is constrained. At Siemens Financial Services, Inc. (SFS), we can offer you tax-exempt financing, which requires less time and effort than issuing a bond and, economically, compares favorably to the costs of issuing a bond.

**Facility:**
El Camino Hospital, Mountain View, CA

**Situation:**
- Building new hospital via bond financing as existing facility did not meet California seismic standards
- Decided to acquire new imaging technology for the new hospital after bond financing secured, but issuing another bond was not an option

**Solution:**
Since El Camino's leadership generally preferred to issue tax-exempt bonds to finance major capital expenditures, Siemens Financial Services offered a tax-exempt lease/purchase agreement.

"Through the financing provided by Siemens Financial Services, Inc., we'll be able to ensure that our new hospital will be equipped with the latest diagnostic technology and allow us to meet our planned opening date."

Marla Marlow, Chief Financial Officer
El Camino Hospital

# Solution: Upgradeable, Cost-Effective & Supported Technology


**Lower investment costs. Lower life-cycle costs.**

Flexible, upgradeable imaging technology that enables you to not only care for your patients today but also be agile enough to meet tomorrow's needs without major re-investment. These are the kinds of innovations Siemens is spearheading to help you provide the services your patients need while offsetting revenues lost by a unfavorable payor mix.

**We're concerned about dose but don't want to buy and then have an obsolete system.**

What if you could obtain high-quality images with reduced dose and ensure that your CT system doesn't become obsolete? It's possible with the SOMATOM® Definition AS CT. The system offers unique dose shield technology that automatically contours and blocks irrelevant areas from receiving dose. It can often be sited and installed in existing spaces thanks to its small footprint. And, it can be upgraded on-site all the way up from a 20- to a 128-slice system.

"We were concerned that if we went with a lower-slice system, we'd need to upgrade in maybe another five years. What Siemens offered fit our needs perfectly."

Sue Campbell, Chief Executive Officer
Community Memorial Hospital

**I need better MRI imaging but can't afford it.**

You may be surprised by the power and quality of the MAGNETOM® ESSENZA 1.5T system. Easy to site and easy to learn, with the MAGNETOM ESSENZA you can perform imaging exams that may currently be referred elsewhere. Your electricity bill and associated AC costs may also be reduced thanks to the system's reduced electrical load and innovative cooling system. And, within about three years after delivery, you'll receive a software and IT hardware upgrade as part of our obsolescence protection program.

"For us, we looked at several systems, and many systems were simply out of our price range. But price wasn't the only determining factor. Our radiologists preferred the MAGNETOM ESSENZA's image quality as well as its ease of use and size."

Donna Walter, Vice President of
Patient Care Services
Northwest Medical Center

## I want a service plan that we will actually use based on our unique needs.

Technology upgrades don't happen in a vacuum. There are your staff, your patients, and your overall bottom line to consider. Your facility may have different service needs than others in your area. Understanding those differences and partnering with you to enable you to decrease service costs, increase coverage as your facility grows, and minimize workflow disruptions are central to Siemens volume-based service contracts.

These service programs are proactive and built to address challenges from budget constraints to evolving technology. In fact, with services like remote monitoring, you'll be notified before a problem occurs, so your system can be maintained during off-hours. With the ability to customize the level of service you require, these service programs can answer your specific needs.

**Streamline Costs & Maximize ROI with Proactive Service Remote Connectivity**

Get the latest equipment performance data and software updates remotely from our service engineers.

**Siemens Guardian Program™**

Have your system remotely monitored in real-time so a Siemens-certified engineer can address a problem before it arises.

**Utilization Management**

In-depth monthly reports and a system overview scorecard help you identify opportunities to increase productivity and find new sources of revenue.

**Obsolescence Protection**

Receive updates and upgrades for software and hardware through our *syngo*® Evolve Package®.

**Access to Siemens Engineers**

24/7 direct access to our technical support engineers, who have, on average, more than 20 years of experience helping customers.


# Surviving the Storm

## Tumultuous Times for America's Small Community Hospitals, Chapter 3

In Chapters 1 and 2, SCAPR covered EHR, access to capital, payor mix, and technology upgrades. Here, in Chapter 3, the last two challenges, physician recruitment and nurse shortages, are covered.

## Challenge: Physician Recruitment

Depending on the definition of rurality used, 17% to 49% of Americans live in rural areas. Residents of these environments, in which most small community hospitals are located, are typically older than city dwellers and disproportionately insured through Medicaid or Medicare, or are uninsured.[1] Consequently, physicians, particularly recent graduates carrying significant debt, are reluctant to work for such facilities because they may not be paid for all of their services. "We have a supply of physicians who can live on Medicaid and Medicare," said James Buckner, CEO of Uvalde Memorial Hospital in Uvalde, Texas. "But the lure of a better payor mix takes specialists elsewhere."

Specialists are what small community hospitals desperately need. Standard-of-care guidelines increasingly call for referrals to specialists and subspecialists for a growing number of illnesses and medical conditions. It is no longer enough for a patient experiencing flashing lights to see an ophthalmic surgeon, for example; he or she is often referred to a retinal specialist.

The growing trend of specialization is rooted in economics. Family-physician salaries are the lowest in the medical profession, averaging $186,000 in 2008[2]. New physicians, meanwhile, are emerging from residency with school debts of up to $250,000[2]. These doctors can become family practitioners and earn a starting salary of $140,000 a year, or they can remain in school one year longer and become anesthesiologists, radiologists, or orthopedic surgeons, all of whom earn closer to $500,000 a year. Additional study and experience can lead to sub-specialization, which may pay even more. Results of a 2009 survey conducted of nearly 1,200 fourth-year medical students found that just 2% were planning to work in primary-care internal medicine[3].

Another factor at work in the specialization trend: Medicare's fee schedule pays less for office visits than for simple procedures[4]. The reimbursement system is structured in a way that DRGs are skewed to reimburse at a percentage rate that is higher for heart surgery, general surgery, and cardiology than for other procedures.

# SCAPR's In-Depth Report:
# Uvalde Memorial Hospital

Uvalde Memorial Hospital (UMH) is licensed for 66 beds and serves 50,000 people who live in five Texas counties. The not-for-profit facility maintains imaging capabilities for nuclear medicine, ultrasound, CT and MRI scanning, bone densitometry, and PACS, among others. Other services available include chemotherapy treatment, heart catheterization, and a wound-care center.

Despite its license for more than 60 beds, UMH is staffed for only 49. Average census is lower still, at approximately 27 beds. If the hospital were capturing a higher number of patients from its service area, CEO James Buckner says the average census would be between 40 and 45. "But we just don't have the doctors to make that happen," he said.

Two years elapsed before UMH was able to replace a cardiologist who left; the vacancy created by a departing orthopedic surgeon is now three years old, despite a recruitment package that exceeds $500,000. The hospital currently employs 14 physicians and needs at least three more. Buckner believes the situation is exacerbated by a deficiency at medical schools. "We have doctors coming out of school entering a challenging revenue environment that they are not trained to deal with," he said. "It's not like we can pay them in chickens."

Nor can UMH compete with the growing subspecialty market. Women diagnosed with breast cancer are choosing to go to certified breast centers rather than to general hospitals staffed with surgeons who are certified in breast surgery, but perform other surgical procedures as well. "We can't be a center of excellence in breast surgery," said Buckner. "We can do great bread-and-butter surgery, but as this specialization trend develops, it's going to be more and more of an issue for us."

**Facility:**
Uvalde Memorial Hospital, Uvalde, TX

**Situation:**
- Has 60 beds but is staffed for only 49
- Needs at least three more physicians
- Faces difficulties competing with specialty centers

"It's not like we can pay them in chickens."

James Buckner, Chief Executive Officer
Uvalde Memorial

[1] American Hospital Association, 2009

[2] Associated Press, September 9, 2008

[3] Karen Hauer, M.D., Journal of the American Medical Association, September, 2009

[4] American College of Physicians

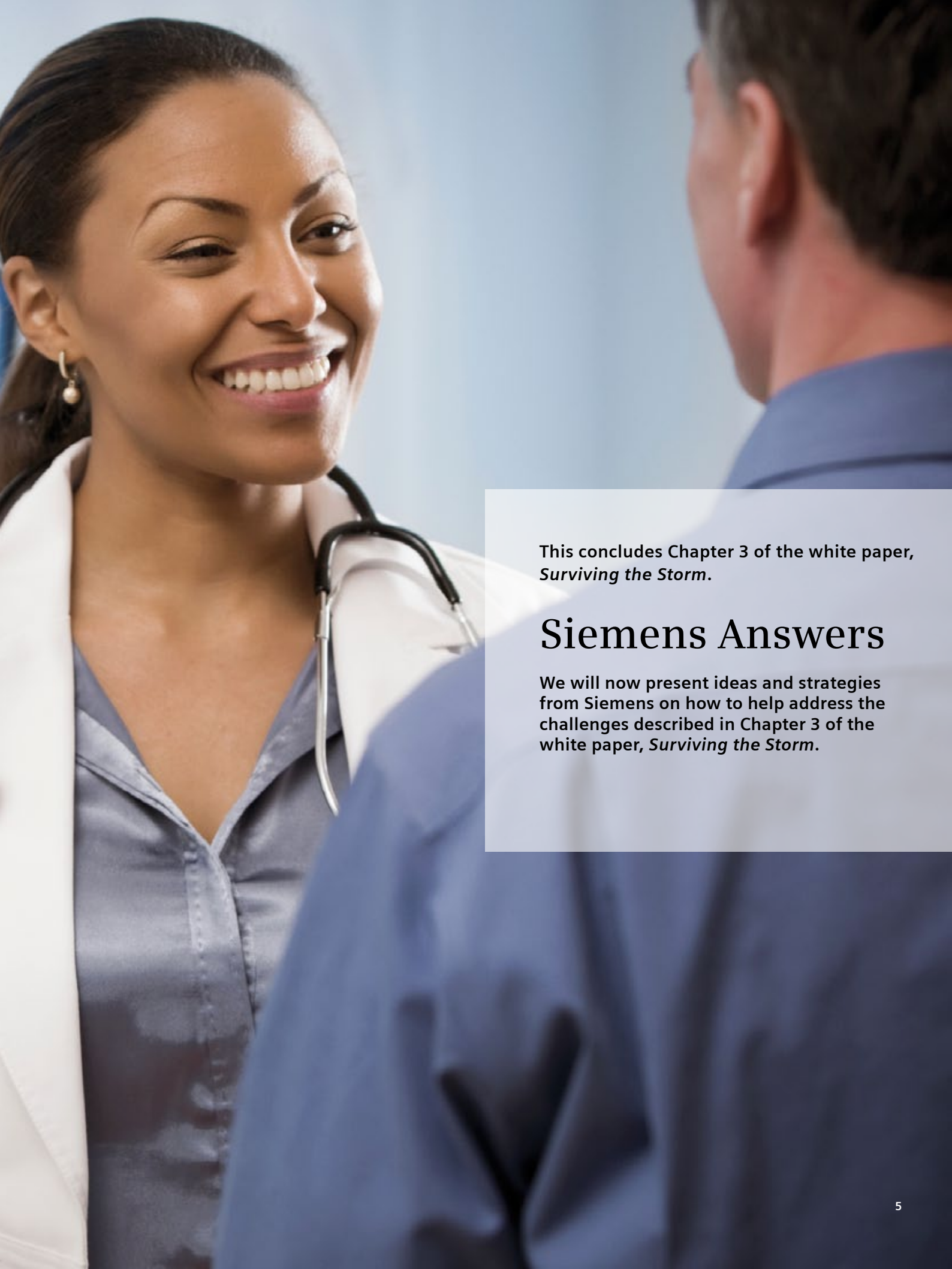
# Challenge: Nurse Shortages

Rising compensation packages offered by wealthier healthcare providers attract the majority of available nursing professionals today, leaving smaller facilities to cope with vacancies and an aging staff of veteran caregivers. Together, physician and staff deficits prevent these hospitals from operating at full capacity when the need arises. Seasonal increases in influenza for example cause a percentage of patients either to be held in Emergency Departments until beds become available—or worse, transferred to other hospitals, resulting in a loss of revenue. "Our surge capacity is a huge problem, and the H1N1 virus makes it even worse," continues Buckner. "When our community is sick, so are our nurses."

One rural, community-based facility has found a solution to the nurse shortage. This Virginia-based hospital, licensed for 192 acute-care and 318 long-term beds, created a scholarship and tuition assistance program in 2001 that provides financial assistance for qualified individuals who agree to attend college and return to work at the hospital after their educational programs are completed. Last year, the health system, of which the hospital is a part, led the establishment of a center of nursing excellence that locally offers education from the level of nursing assistant to master's programs. The CEO of this facility said, "We understand the importance of growing our own."

Yet, the hospital is an exception in this regard, both among small community hospitals and U.S. hospitals as a whole. Despite a reported easing of the nursing shortage in all U.S. hospitals this year due to the recession, a recent study found that the shortage is projected to grow to 260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s[5].

[5] Peter Buerhaus, *Health Affairs,* July-August, 2009



**This concludes Chapter 3 of the white paper, *Surviving the Storm*.**

# Siemens Answers

**We will now present ideas and strategies from Siemens on how to help address the challenges described in Chapter 3 of the white paper, *Surviving the Storm*.**

# Solution: Real-Life Technology for Improved Staff—and Patient—Satisfaction

When it comes to recruiting challenges, there are two basic ways to attract employees: pay them more or provide them with the tools they need for the greatest success, both at your facility and in their careers. Siemens technology is used at hospitals throughout the world, making access to it an asset for physicians and nurses whether they work at your or another facility throughout their careers.

Further, many of Siemens' employees are former clinicians; they understand the real-life challenges your staff faces and have helped engineer affordable solutions to help overcome them. These easy-to-learn and easy-to-use systems can improve staff and patient satisfaction, enabling better employee attraction and retention as well as improved efficiency.


"The system operations are very smooth and the Siemens training was very good. Our staff is very comfortable on the system. In fact, I don't think you could get them to switch back."

Cindy Steenstra, Imaging Director
Ridgeview Medical Center, Waconia, MN

**We need a low dose CT that makes workflow easier and faster for my staff.**

Engineered for its powerful simplicity, the SOMATOM® Definition AS is easy to learn and use, making high-quality CT exams fast, efficient, and effective. With this system, your clinicians will be able to perform low-dose exams, which are an important concern for your referring physicians and patients. And, they can image a wide spectrum of patient profiles, from pediatric to bariatric, thanks to the system's 78-cm bore and 660-lb. patient weight table. Personalized Siemens training helps your staff be productive with the system right from the beginning. In fact, a special training program is available if you are switching from older equipment to a new Siemens CT scanner.


### We need an MR system with outstanding image quality in a small footprint.

Your staff can diagnose the most challenging diseases quick and effectively with the MAGNETOM Espree™. One of the world's first 1.5T open-bore MRIs, the MAGNETOM Espree offers a 70-cm internal bore, short 125-cm system length, 1.5T field strength, and innovative Tim® technology to widen clinical capabilities, enabling improved throughput and better profitability. With it, you'll experience revolutionary performance, increased patient satisfaction, and a broad array of applications, enabling your clinicians to do more than they thought possible.

### We need an ultrasound system that enhances clinical confidence and is adaptable to the way we work.

The ACUSON S2000™ ultrasound system for general and shared imaging and the ACUSON SC2000™ volume imaging ultrasound system for cardiology offer clinicians outstanding image quality and superior ergonomics. And, their workflow protocols walk a sonographer step-by-step through an exam, ensuring a comprehensive study with fewer keystrokes. Would it help your staff to adapt the system workflow to their daily workflow? Of course it would. With advanced automation technology and workflow protocols, these ultrasound systems enable you to greatly reduce exam times and increase reproducibility.


**A cornerstone of the nation's overall health, community hospitals are integral to the care of their residents. Whether in rural or more urban locations, community hospitals must strike a balance between what is realistically achievable for a facility of their size and what is beneficial for the health and welfare of their patients. As such, community hospitals face several distinct challenges, as highlighted in this three-part series. At Siemens Healthcare, we strive to not only understand but also answer those challenges with solutions that are practical, affordable, and impactful to the health of your community. For more information on Siemens' community hospital solutions, please visit www.usa.siemens.com/commhosp.**

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