

PAYERS & PROVIDERS

CALIFORNIA EDITION

Calendar

January 24-27

HFMA Regional Conference.
Caesar's Palace, Las Vegas. David Brailer, M.D., is the keynote speaker.

\$595-\$845

Register Online:

<http://www.hfma-region1-symposium.org/>

February 10

Hospital Association of Southern California Second Annual Palliative Care Conference. Pacific Palms Resort, City of Industry.

Speakers and breakout groups will make the growing business case for palliative care. \$225-\$250.

Register online:

<http://www.hasc.org>

February 10

Insured The Uninsured, 14th Annual Conference. Sacramento Convention Center.

A symposium on how to reduce the ranks of the uninsured. \$45-\$175.

Register online:

<http://itupconference.eventbrite.com/>

E-Mail info@payersandproviders.com with the details of your event, or call (877) 248-2360, ext. 3. It will be published in the Calendar section, space permitting.

From Feast To Famine For Nursing

Recruiting Plummet; New Graduates Struggle

Just a few years ago, California's nurses were healthcare's rock stars – lured to new jobs with hiring bonuses, low-interest home mortgages and even cars.

The steepest recession since the Great Depression has put a kibosh on the party – at least for now.

"The hiring of nurses is certainly not as aggressive as two or three years ago," says **Jan Emerson**, vice president of external relations for the **California Hospital Association**. "For the past year or 18 months, many hospitals have put in hiring freezes, or have frozen wages."

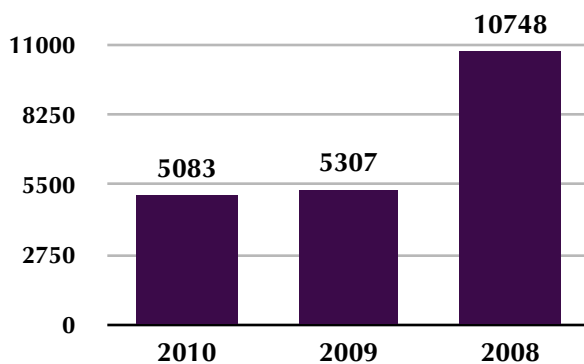
Emerson's observation may be an understatement: according to the **California Institute for Nursing and Health Care**, projected nurse hiring is now less than half of what it was in 2008. The statewide vacancy rate for jobs has also dropped from 7% to less than 5% in the past two years.

"The economy has created a very unexpected aberration," says CINHC Executive Director **Deloras Jones**.

Emerson and Jones attribute that in part to many veteran nurses retaining their positions past planned retirement. Many are doing so because their investment portfolios took a beating in the down stock market, or they have a spouse who has lost a job and they need the income.

Moreover, many hospitals are saving money by hiring only veteran nurses who do not have to undergo expensive on-the-job training. As a result, as many as 40% of newly minted nurses cannot find a job, according to

Nurse hiring in California (2009 and 2010 numbers estimated)



Source: CINHC

CINHC data.

Salinas Valley Memorial Healthcare System is one such institution. With a nurse vacancy rate that's shriveled from 12% a few years ago to 4% today, the 269-bed hospital hired no new nursing school graduates in 2009 and has no plans to do so in 2010. Before the

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In Brief

Stanford Revises CME Process

Stanford University School of Medicine will revise its continuing medical education (CME) curriculum to include private industry donations without undue outside influence.

Stanford has accepted a \$3 million gift from drug industry giant **Pfizer, Inc.** to design a new medical education curriculum. The money comes with no strings, or input from Pfizer.

"We set out to see if industry would be willing to partner with us to create a high-quality curriculum, under the condition that Stanford faculty would choose the topics and design the curriculum independent of the relationship with industry," says **Robert Jackler, M.D.**, Stanford's assistant dean in charge of continuing medical education. "We sought not to prevent partnerships with industry, but rather to redefine it." He adds that the ultimate goal of designing a new CME curriculum is to improve patient care and focus on issues specific to Stanford physicians.

The connection between CME and companies that can benefit by influencing physicians has been under scrutiny for the better part of a decade, with widespread incidents of drug companies sponsoring marketing-heavy seminars where physicians received CME credit in lieu of attendance.

"Our multi-year support of Stanford's efforts demonstrates our willingness to help redefine how CME is funded so that practicing physicians can get access to the latest science, presented in ways that unquestionably put the interests of the patient first and foremost," says **Freda Lewis-Hall, M.D.**, Pfizer's chief medical officer.

Continued on Page 3

Nurses (Continued from Page One)

recession, it regularly hired 30 or so recent nursing school graduates a year.

"Three years ago, everybody was hiring new graduates, but that's changed," says **Cynthia Hopkins**, Salinas Valley's nurse recruiter.

Hopkins adds that some nurses are even piling on extra shifts away from their regular jobs, creating some concern about on-the-job fatigue. She shies away from hiring anybody she believes is working at more than one facility.

The hiring slump is occurring even as the state struggles with an ongoing acute nursing shortage – a trend officials are concerned could aggravate the shortage in the long-term.

"Everyone agrees as the economy rebounds, a lot of people will leave their jobs, and there will be a huge need for hiring," Emerson says.

However, a ramping up of nursing education programs earlier in the decade has left so many new graduates without work there are concerns many will seek jobs out of state, or abandon nursing altogether – making California's long-term shortage even worse.

As a result, CINHC is using a recently procured \$500,000 grant from the **Gordon and Betty Moore Foundation** to create internship programs at community clinics to expand the skills of recent graduates and make them more marketable. Although the program would be limited to the Bay Area, Jones says her organization is also trying to secure a \$5 million grant from the U.S. Department of Labor to expand such internships statewide.

"This will give the graduates an opportunity to practice nursing until they can secure jobs," Jones says.

Anthem Hopes To Tip Scales On CHF Wireless Pilot Project Strives to Cut Hospitalizations

Anthem Blue Cross of California has teamed with a Canadian company to better manage the health of its commercial managed care patients who suffer from congestive heart failure (CHF).

The ailment, which affects tens of thousands of Californians, occurs when a weakened heart is unable to pump effectively, causing fluids to accumulate in bodily tissues. It can be controlled with a low-salt diet and a variety of drugs, but a lack of close monitoring can force patients to be hospitalized for days at a time.

Blue Cross has only about 400 enrollees in its commercial health maintenance organization with CHF, but the condition is extraordinarily costly to manage: up to \$30,000 per member per year, according to Blue Cross of California Medical Director **Kurt Tamaru, M.D.** Most of that cost is tied up in hospitalizations – on average, each commercial enrollee with CHF is

admitted as an inpatient about once a year.

A pilot project involving 100 of Blue Cross' commercial health maintenance organization enrollees with CHF and a bathroom-style scale launched last week. The

enrollee uses the scale once a day, and it wirelessly transmits their weight to their provider. About a dozen medical groups that contract with Blue Cross are participating. Warnings are also supplied to both providers and patients if there is a significant increase in weight over a short period of time – two pounds a day or five or six pounds in a week. It's a sign the condition is not being properly managed. The patient is also prompted by another wireless device to disclose if they are having shortness of breath or other symptoms suggesting their condition is out of control.



This bathroom-style scale is used to wirelessly transmit weight data on Anthem enrollees with congestive heart failure. Source: Ideal Life

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In Brief

Lung Association Blasts California on Tobacco Policies

The **American Lung Association in California** has given the state failing grades for tobacco prevention and control spending, and concludes it has made a lackluster effort in terms of its maintaining its cigarette tax and smoking cessation programs.

It's the second year in a row California received an "F" for its tobacco prevention programs. The Lung Association claims that the state's allocation of funding is one-fifth the level recommended by the **Centers for Disease Control and Prevention**.

The state also received an "F" for its tobacco tax, which at 87 cents per pack is more than a third below the national average of \$1.34 per pack. The report card noted that legislation the Lung Association sponsored that would have raised the tax to \$1.50 a pack and raise an additional \$1.2 billion in revenue has stalled in the state Senate. Action on the bill, SB 600, authored by **Sen. Alex Padilla**, D-Van Nuys, was suspended last summer.

About 4 million Californians smoke, and some 37,000 of them die each year from smoking-related illnesses. Smoking-related costs are about \$18 billion a year.

"It's time to raise the grade. For all Californians, strong tobacco control policies must be a top priority," says **Jane Warner**, chief executive officer of the Lung Association in California.

California did receive an "A" grade for restricting smoking in public places. And four cities in California – Richmond, Calabasas, Albany and Glendale – received overall grades of "A."

CHF (Continued from Page Two)

Most of Blue Cross' CHF enrollees are prompted to supply their weights to providers on a regular basis, but the data is often incomplete. They are also encouraged to call their physicians if there is a sudden weight gain, but that doesn't necessarily mean they will get a quick appointment, according to Tamaru.

The devices are provided by Toronto-based firm **Ideal Life**. Company President **Jason Goldberg** believes the equipment makes it far easier to monitor a chronic condition such as CHF.

"The purpose is to align close monitoring with routine daily activity, such as weighing one's self in the morning," Goldberg says. Ideal Life supplies the scales

to clinic patients in the eastern U.S. and in some parts of California, but has yet to work with a mainstream commercial health plan.

Tamaru hopes that the transmission of data in real time – along with closer coaching of patients to improve their lifestyle and see a doctor more quickly if they need it – could cut CHF management costs by up to 40%.

"Catching patients earlier, before they need hospitalization, is a key to managing their conditions better and improving their lives," he says.

The Ideal Life devices only need to cut costs by 1% for Blue Cross to break even. If the pilot proves successful, Blue Cross will use it will all its CHF patients in California, officials say.

Molina's Fourth Quarter Dips In Red

Rising Expenses Take Toll on Insurer's Bottom Line

Molina Healthcare may post a loss as high as \$6.4 million for the fourth quarter of 2009 ending December 31, according to guidance issued by the Medicaid insurer this week. That's a huge swing from the \$14.8 million in net income posted by Molina a year ago.

Molina Chief Executive Officer **J. Mario Molina, M.D.**, attributes the projected losses in part to increased costs associated with caring for patients suffering from the H1N1 swine flu virus. He notes that the flu virus hit California, Michigan and Washington particularly hard. Those states comprise about 75% of Molina's business, Molina told investors at the **J.P. Morgan Healthcare Conference** in San Francisco on Tuesday.

"This was a big driver for the flu costs for us...the flu has hit children more than adults," Molina says, adding that the rates paid to cover children are less than other populations.

Partly as a result, the medical loss ratio for

Molina in the fourth quarter was 87.2%, up from 84.7% in the fourth quarter of 2008.

The Long Beach-based Molina has also been experiencing leaps in membership growth over the past year. "Typically we see organic growth of two to three percent, and our organic growth has been running 10% to 12%," Molina says. He adds that new members initially come with higher costs, although claims tend to flatten out a few quarters after a member is added.

Molina notes that Medicaid rate decreases in New Mexico and Washington also contributed to losses. Higher administrative costs, such as Medicare marketing, moving a call center from California to New Mexico, and higher premium taxes in Ohio, were also blamed.

Molina believes that if a healthcare reform package is passed, the insurer will have to balance a larger number of enrollees with higher medical costs.

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Healthcare Trends Of 2010 – Part I

As Always, Eyes Will Have to Stay on Bottom Line

1. Healthcare Reform: Payment and Payer Mix Changes

Assuming that full healthcare reform is passed by Congress, actual implementation will take months and, in some cases, years. The most profound impact will be felt in reimbursement changes – impacting Medicaid, Medicare, Disproportionate Share Hospital payments, and even commercial payment rates. Anticipate that the majority of services hospitals provide will be reimbursed at or near Medicare rates.

2. The Economy

Unemployment will likely remain high through 2010. This will keep demand soft for healthcare services, and bad debt will persist at current levels or go up. Charity and indigent care levels will also remain high as PPO enrollment increases and volume softens. Enrollment in Medicare Advantage will remain fairly constant until changes to premiums and benefits kick-in. Medicare Advantage providers will feel the impact of reimbursement reductions this year. However, Hierarchical Condition Category (“HCC”) and Risk Adjustment Factor (“RAF”) improvements will not change for one year.

3. Physician – Hospital Alignment

Healthcare reform initiatives will favor primary care and will be tough on specialists and sub-specialists. Physician supply will be re-calibrated through the economics of reimbursement, from educational subsidies to payment levels for procedures. As medical home and accountable care organizations (“ACOs”) take root, primary care physicians are once again headed to the front of the “food chain.” Specialists will become integral players in the implementation and use of clinical care protocols as hospitals continue to drive down the cost of care. Hospitals will work closely with specialists as bundled payments, clinical integration, and value-based purchasing (“VBP”) programs continue to grow.

As in the past, expect physicians to show preference for employment by hospitals, health plans, and large medical groups, which offer safety in numbers, ease of practice, and more balanced lifestyles.

4. Clinical Integration and Changing Delivery Models

Hospitals and physicians will further align clinical and financial incentives patterned after entities that have created models that meet federal and health plan guidelines and rigorous standards of integration. Bundled payment structures (e.g., acute care episodes, VBP) for selected cardiac and orthopedic procedures are being piloted currently and will likely expand to other providers and procedures.

ACOs will be introduced with the objective of allowing qualified providers to assume responsibility for overall costs and quality of care for defined populations. Further, bundled payments are likely to expand to cover pre-admission (two to three days) and a longer timeframe post admission (30 to 60 days).

5. Consolidations and Closures

Hospitals that cannot survive will be acquired, converted to alternative use, or closed. Expect to see a number of hospitals close during the next five years. Hospitals that survive will generate sufficient patient volume (e.g., operate at 90% to 95% occupancy), manage payer mix, significantly reduce overhead, and achieve high throughput. Look for more development of “hub and spoke” delivery systems, with the “spokes” being more outpatient and physician offices.



By
**Steven T.
 Valentine**

Steven T Valentine is President of The Camden Group, a national healthcare consulting firm in El Segundo. He is a member of the Payers & Providers Editorial Board.

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*New England Journal of Medicine, 2004.

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