



VOLUME 12—FALL / WINTER 2010

## PRESIDENT'S CORNER



Tim Campbell  
President

Change is upon us — perhaps the most significant that we've seen in decades. In

this age of economic challenge, shifts in payer mix and healthcare reform, we, like you, are facing a "new normal" in how we operate and provide value to our partners.

Today, most if not all of us are working to reevaluate our operations and capital structure. We're streamlining our processes and working hard to reduce and control costs while we drive continuous improvement in clinical outcomes and patient satisfaction. Simplification, Clarity and Accountability have become buzz words across the healthcare industry.

But wait... Is this need to drive costs out of the system while improving quality really new — or is it just new to us in the healthcare space?

Those of us who were around in the 1980s and early 1990s will recall terms and phrases like Total Quality Management, Kaizen, Six Sigma, Quality Improvement Teams and Returning To Core Competencies. We'll also recall names like W.E. Deming, J.M. Juran and Philip Crosby. The challenge of that era was how to make American manufacturing, particularly automobile manufacturing, competitive with the Japanese in terms of cost and quality. The sense was "do or die" for the American auto industry and books like *Quality Is Free*, *Out of the Crisis*, *The Deming Management Method* and *Juran's Quality Handbook* were the required reading of the day.

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## Sorting Through the New Normal

"The degree of change facing hospitals under healthcare reform and other industry structural shifts are even more fundamental than the change they experienced with the DRG payment transition in the 1980s; touching all aspects of hospital operations and capital strategies," a recent Moody's Investor Service report says.

In the wake of the recession, hospitals are now working to sort out what changes reform will demand on their operations. Costs certainly will remain a top concern, but many hospitals worked to rein in their spending during 2009. Now it may be time to start thinking about the potential flip side of cost cuts as they begin to meet the requirements of reform.

**Will the cost cutting that happened during the recession lead to revenue reductions for poor performance under reform?**

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*Hospitals & Health Networks* magazine recently reported on an aspect of the law geared to performance, stating that: "starting October 2012, all acute care prospective payment system hospitals with sufficient volume will be included in a value-based purchasing initiative. Funded by inpatient DRG payment withholdings of one percent in FY 2013 and rising to two percent in 2017 and beyond, bonuses will be based on a yet-to-be-determined formula that must include established process measures for heart attack, heart failure, pneumonia and surgical care; clinical outcome measures including hospital-acquired infections; patient perceptions from the HCAHPS survey; and efficiency measures, including Medicare spending per beneficiary."

What this means is that over the next three years, hospitals will be required to participate in new Medicare and Medicaid programs similar to Medicare's Pay for Performance programs. The values will not be defined until the regulations are written, but the overall direction is clear. Several general requirements included focus on quality and patient satisfaction measures that will impact eligibility for performance bonuses.

### How significantly will these programs impact financial outcomes?

The bottom 25th percentile on factors such as patient satisfaction, hospital acquired infections or readmission rates will result in an absolute reduction of payment.

Imagine that a quarter of all hospitals (regardless of where the curve falls) are going to see a reduction in their Medicare payment. Given small margins, this may

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**President's Corner**

The challenge for us in the healthcare space today is remarkably similar. I hear from many of our industry executives that the long-held adage of “No Margin, No Mission” is making way for a new phrase — “No Outcomes, No Income.” Whatever we call it, there’s no doubt that “new normal” is shorthand for operating in “changing and challenging times.”

I believe we can learn a great deal from the TQM era of the 80s and 90s and apply many of the same practical leadership and business lessons to our healthcare challenge today.

We as leaders must think differently — about everything. ■

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**Sorting Through the New Normal**

mean the difference between profitability and loss for many.

“While hospitals have been focused on cost-cutting efforts, it is important for them to remain cognizant of the competitive implications that patient satisfaction and quality measures are going to have in the next few years,” said Richard J. Umbdenstock, FACHE, President and Chief Executive Officer of the American Hospital Association at the Association’s 2010 Annual Meeting. “The AHA believes that successful hospitals will take a proactive approach to ensure that they are operationally ready for these measures.”

Presently, hospitals are falling into three categories of preparedness. The early adopters that are aggressively designing their strategies now to meet future requirements around patient satisfaction and quality; the

hospitals that are thinking about the pending changes, but are still focused on cost control; and the hospitals that are waiting to see what the regulations will bring and will then adjust their strategies to meet the changes when they come.

Excelling under this “new normal” will require a “re-think” of all areas of operations and capital strategies.

ARAMARK Healthcare is in a position to leverage best practices across its network of more than 1,000 hospitals and to drive efficiencies that will help its hospital partners to operate in a more competitive way under the new healthcare reform law.

*To learn more about how support service management can become part of your reform strategy, please contact Mary Ann Wyman, RD, LD, Senior Vice President, ARAMARK Healthcare, at [wyman-maryann@aramark.com](mailto:wyman-maryann@aramark.com). ■*

## HEALTHCARE REFORM STRATEGY: TRANSITION EMPLOYEES TO A SUPPORT SERVICE PARTNER

Like most healthcare professionals, support service employees, whether hourly or managerial, perform at their highest levels when they feel that their daily efforts contribute to a greater patient care outcome. ARAMARK Healthcare can best enable this engaged culture, and in turn maximize your support service dollars, when support services labor is on our payroll.

When support service employees are part of ARAMARK Healthcare, they are not only well trained, but focused on operating standards and procedures that drive consistency and more predictable outcomes. Employees benefit from this clarity. They not only know what is expected of them daily, but receive added technical and service training that specifies how what they do makes an impact — in patient, employee, nurse and physician satisfaction, and operational efficiency.

Hospitals benefit in two major areas: labor productivity and reduced risk. For example, while OSHA Incident Rates for

healthcare average 7.7 nationally, ARAMARK Healthcare is proud to be 55% below the industry average at 4.3. That translates to bottom line results for your organization.

The ARAMARK Healthcare labor migration process focuses on engaging support services employees at each step and features key components including:

### 1. Planning and lock-step communication –

The hospital leadership and HR teams, along with ARAMARK Healthcare, coordinate every step of the way to establish the sequence of events, communication plans and ongoing management of the transition. Face-to-face communication from the hospital’s senior leadership and ARAMARK Healthcare leadership to employees is crucial. The communication strategy and channels are designed to anticipate and address concerns that employees might have related to pay, benefits and work processes.

**2. Cultural integration** – It is important that support services employees, particularly long-time employees, understand that the hospital culture they are used

to will be preserved. At ARAMARK Healthcare, our management teams work very hard to engrain the cultures of its hospital partners within the support service functions that it provides. This includes transparent involvement within cross-functional committees, participation in events and employee celebrations.

**3. Professional development** – Employees working in support service roles within hospitals often have limited career-path potential within a single hospital location or system versus the opportunities available with an international support service partner. At ARAMARK Healthcare, when employees transition into the organization, they have much greater opportunity for advancement both within healthcare and beyond into other ARAMARK divisions. In addition, an investment in platforms for customer service, technical and leadership training ensures that employees are continuously developing in their profession. ■



# Maximizing Reimbursement Potential Through Nutritional Services

Hospitals looking to maximize Medicare and Medicaid reimbursement have an opportunity to tap into clinical nutrition expertise through their support service partners to help with their efforts.

Under the healthcare reform law, hospitals may realize increased reimbursement as a result of the potential for expanded coverage for outpatient Medical Nutrition Therapy (MNT) as part of the Patient Protection and Affordability of Care Act. Nutrition education for specific disease states are expected to become increasingly

and nutritionists to provide MNT and plan meals. The report also notes that hospitals will continue to contract with outside agencies for food service as they move MNT to outpatient care facilities.

In October 2007, the Medicare Severity – Diagnosis Related Groups (DRG) program was introduced by the Centers for Medicare and Medicaid Services. RDs play a role in the identification of patients meeting the malnutrition DRG criteria and work collaboratively with physicians and health information management coders to



**“What we are seeing is that dietitians can play a role in increasing reimbursement for hospitals by helping them to structure programs focused on outpatient Medical Nutrition Therapy as well as inpatient malnutrition coding.”**

*Sharron Lent, RD, LD, Senior Director of Patient and Clinical Services, ARAMARK Healthcare*

eligible for reimbursement. In addition to changes under the new law, more reimbursement funding can also be secured by focusing on stricter processes related to inpatient malnutrition.

“What we are seeing is that dietitians can play a role in increasing reimbursement for hospitals by helping them to structure programs focused on outpatient MNT as well as inpatient malnutrition coding,” said Sharron Lent, RD, LD, Senior Director of Patient and Clinical Services with ARAMARK Healthcare. “On the inpatient malnutrition side, we’ve seen the potential for significant increases in reimbursement.”

This is a trend supported through the employment outlook for registered dietitians. The Bureau of Labor Statistics in its 2010-2011 Occupational Outlook Handbook notes that hospitals will continue to require a large number of dietitians

proceed with insurance company billing upon the agreement of a malnutrition diagnosis. ARAMARK Healthcare dietitians have been working to support the company’s hospital partners in maximizing reimbursement from malnutrition diagnosis as a result of the DRG program.

Overall, ARAMARK Healthcare has a strong clinical nutrition practice as one of the world’s largest employers of Registered Dietitians, with more than 750 on ARAMARK payroll. Much of the company’s professional development and programmatic strategies are aligned through its corporate partnership with the industry’s leading professional organization, the American Dietetic Association (ADA).

*For more information about how the clinical nutrition function can help support your reimbursement efforts, please e-mail Sharron at: [lent-sharron@aramark.com](mailto:lent-sharron@aramark.com). ■*

## MEDICAL NUTRITION TOOLKIT OFFERS RESOURCE FOR ARAMARK DIETITIANS

Recognizing the reimbursement potential of clinical nutrition programs under the new healthcare reforms, ARAMARK Healthcare recently released a Medical Nutrition Therapy (MNT) Toolkit to support the company’s more than 750 registered dietitians in developing effective outpatient MNT programs at their partner hospitals.

The web-based resource offers a standardized approach, features the latest Centers for Medicare and Medicaid Services guidelines, and incorporates ARAMARK Healthcare’s practices as well as resources from the American Dietetic Association. In particular, the toolkit contains guidelines for registered dietitians and hospital billing and coding teams to review to ensure that the billing procedures for MNT are designed for maximum reimbursement potential. ■



## Supporting Long-Term Capital Resource Management Through Strategic Medical Equipment Investment



In the past, hospitals traditionally attempted to keep their clinical capital equipment in service an average of approximately 10 years before replacement. This thinking has changed with the capital crunches over the past decade. The trend now is geared to extending equipment age to the very end of useful life, which can last as long as 12 to 16 years for some pieces.

Because of limited capital, hospital departments have historically only approved the purchase of new equipment when existing equipment is significantly beyond recommended useful life. This often led to the purchase of equipment with significantly more capability than currently required, since the user would again be faced with using the equipment longer than desired.

Despite best intentions, this approach often creates a cycle of upfront overspending, using the technology longer than advised and then ultimately overspending again for a replacement piece of equipment.

A different strategy might include a mix of old and new technologies that better

match the level and capabilities of the equipment with a hospital or system's clinical needs. Procuring or deploying older or pre-owned equipment under the correct circumstances enables hospitals to maximize the average age of their equipment portfolio, while still meeting clinical needs — thus enhancing the equipment's value.

For example, a CT scanner that no longer meets the demands of a busy Emergency Department might still offer value in another clinical location with lower volumes. *(See page 5 for strategies regarding medical equipment redeployment within a healthcare facility.)*

**Overall, deferring significant capital spending and cascading equipment can help hospitals to better manage clinical equipment expenses.**

Another scenario where pre-owned equipment might make sense is when a hospital has a very expensive device at the end of its life cycle, but a replacement timeline that is a few years away. This often occurs when a hospital plans to purchase new clinical equipment in coordination with the opening of a new building or wing. Many times a pre-owned replacement tested to meet quality standards can be purchased for a cost that would be comparable to maintaining the original device and be better suited for the clinical need.

Overall, deferring significant capital spending and cascading equipment can help hospitals to better manage clinical equipment expenses. This strategy may not solve long-term technology needs, but it can enable hospitals to build bridges within their capital spending timelines and generate greater utility from their total mix of equipment.

### **A Buying and Selling Resource**

ARAMARK Healthcare's Clinical Technology Services group represents the country's largest independent provider of clinical technology services, working with more than 570 hospitals. This puts the

organization in the position to maintain and evaluate a large volume of equipment from every major manufacturer and to provide unbiased counsel on the best options to meet a hospital's clinical need.

To leverage this national perspective, ARAMARK Healthcare Clinical Technology Services is pilot testing a new online resource called DOTmed Platinum. The tool functions as a brokerage for hospitals and health systems to buy

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**Supporting Long-Term Capital Resource Management through Strategic Medical Equipment Investment**

and sell pre-owned clinical equipment, including high-end imaging equipment such as CT scanners, MRI scanners and nuclear medicine, cardiac catheterization and general radiology equipment. The tool also offers transfer of smaller pieces of biomed equipment such as OR monitors and anesthesia machines.

One of the benefits of this resource versus other equipment auction services is the ARAMARK Healthcare Clinical Technology Services teams have insight into how each piece of equipment offered on DOTmed Platinum has been maintained, because ARAMARK Healthcare either performed the service directly or tracked the service

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*Larry Hertzler, Vice President of Clinical Engineering, ARAMARK Healthcare*

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on behalf of our partner hospitals. The closed network enables ARAMARK Healthcare to evaluate how much useful life a piece of equipment has remaining, which is very difficult to determine when purchasing pre-owned equipment on the open market.

The service also provides a means for hospitals to divest equipment at maximum market value. An Original Equipment Manufacturer (OEM) often will offer to remove an old piece of equipment when a replacement is purchased. However, the motivation of the OEM is to sell the new piece and remove the old piece from service as soon as possible... particularly if the old piece is manufactured by a competitor. Often, the equipment being replaced still has significant value, so having an opportunity to cascade or sell it on the open market, as opposed to simply disposing of it by trading it in, enables hospitals to realize a better return.

The DOTmed Platinum tool utilizes a tiered approach in the listing of clinical equipment items. Initially, equipment is made available only to hospitals that are in the same system or group, which is helpful for those partners who wish to

redeploy equipment from site to site. Then, after a pre-determined period of time, the equipment is offered to hospitals within ARAMARK Healthcare’s partner hospitals and healthcare facilities. The final phase of the service is to auction equipment on the open market, if there are no takers within the other channels.

“We’ve learned that once multi-site interests become aware that equipment is available, they are generally interested in cascading assets within their locations first before divesting them,” said Larry Hertzler, Vice President of Clinical Engineering, ARAMARK Healthcare. “This resource gives hospitals the first crack at a piece of equipment within their group that is coming out of service, as well as a channel to procure and divest their technology assets.”

*For more information about how you can evaluate your mix of clinical technology or to learn more about this new resource for the sale and purchase of pre-owned medical equipment, email Larry Hertzler at [hertzler-larry@aramark.com](mailto:hertzler-larry@aramark.com). ■*



## Environmental Services — A Lynchpin in Battle Against Hospital-Acquired Infections

With public perception and federal reimbursement at stake, experts say hospital cleaning practices are more critical than ever in helping to reduce hospital-acquired infections (HAI).

National healthcare reform, particularly new guidelines for reporting HAI rates publicly, is driving the renewed focus.

“It starts with senior leadership making a commitment in public to tackle HAI

hand sanitizing, and new technologies, like ultraviolet light, vaporized hydrogen peroxide disinfection, and silver and copper materials that prevent bacteria from reproducing, have helped providers make strides in reducing HAI.

“Even before healthcare reform, patients had become more acutely aware of HAI,” said Candy Dewar, Administrative Director for Patient Safety and Quality at Susquehanna Health, a three-hospital

infection steps, switching from cleaning multiple patient rooms with mops and buckets to microfiber mops that are replaced after each room and that remove 95 percent of bacteria helps Susquehanna Health reduce its risk for infections, for example.

“It eliminates the risk of cross-contamination because we’re using new cleaning materials in each patient room,” said Gordon Buntrock, Director of Environmental Services Operations Support for ARAMARK Healthcare.

Sheila Koskey, Director for Infection Prevention and Control at Susquehanna, also points to Pennsylvania’s early prioritization of HAI as a factor in reducing infection rates. Passed in 2007, Pennsylvania’s Health Care-Associated Infection Prevention and Control Act (Act 52), requires state healthcare facilities to report HAI rates to government oversight agencies. Statewide, the rate dropped 12.5 percent in 2009 compared to 2008.

Highlighting that success, two hospitals within the Susquehanna Health system received VHA Pennsylvania Achieving Patient Care Excellence (APEX) Awards in 2010 for eliminating ventilator-associated pneumonia and posting high scores in Core Measures at Williamsport Regional Medical Center, and eliminating symptomatic catheter-associated hospital-acquired urinary tract infections at Muncy Valley Hospital.

Dewar said Susquehanna’s comprehensive infection prevention and control program positions the system well for healthcare reform and that it will take a team effort to achieve its goal of eliminating HAI. ■

**Improving labor allocation through ARAMARK’s proprietary ISISpro technology platform, which enables the hospital’s leadership to monitor housekeeping coverage and redirect resources, has made an impact.**

and the recognition that it’s a huge team effort,” said David B. Nash, Dean of the Jefferson School of Population Health in Philadelphia.

On the frontline, Nash said, communication between infection prevention staff and environmental service providers plays a significant role in executing the gameplan.

“There’s really been a shift in our thinking,” Nash said. “The individual worker is playing a role here beyond their job description in reducing this scourge and understanding their responsibility.”

On the floor, implementing processes such as mandatory “foam in-foam out”

system in Pennsylvania. “They expect us to keep them safe from infections. Patients and visitors often associate the cleanliness of the facility with infection prevention efforts.”

Susquehanna has made infection prevention and control a top priority and has enlisted its environmental services provider, ARAMARK Healthcare, to help.

Improving labor allocation through ARAMARK’s proprietary ISISpro technology platform, which enables the hospital’s leadership to monitor housekeeping coverage and redirect resources, has made an impact.

New and better cleaning materials have also contributed. Along with other key



# Strategies for Medical Equipment Redeployment

Today's increasingly challenging healthcare environment is motivating hospital leaders to reevaluate spending priorities to maintain a strong balance sheet.

High-end clinical equipment should be evaluated in terms of its ability to enhance care, provide market distinction and generate incremental volume as part of an overall strategic planning process. Needless to say, the economic analysis surrounding how clinical equipment fits into the hospital's overall strategy is critical.

Part of a comprehensive strategy should be an analysis of equipment usage volume and where it is in its life cycle.

When a piece of clinical equipment with remaining life becomes under-utilized in its current location, it could still be able to generate revenue for the hospital. Would another department have greater utilization? Redeploying medical equipment resources within an enterprise can support a long-term capital resource management plan.

Here are some considerations when developing a formal medical equipment redeployment strategy:

- › Develop a roster of medical equipment that has a solid "functional" life of at least three years and has good parts availability. A unit's functional life is not solely contingent on its years of useful life, but rather its ability to effectively support clinical functions.
- › Understand current and near-term clinical needs, so redeployment candidates are matched with a clinical area that can seamlessly integrate the equipment into its daily operations.
- › Consider IT compatibility when transferring a piece of equipment. Depending on the type of equipment and the level of Electronic Medical Record integration achieved within the receiving clinical area, incorporating a foreign system into the equipment mix may not be appropriate.



- › Calculate all associated costs with moving a piece of equipment to another area. Portable units should represent minimal costs, but fixed units can vary greatly depending on their size, scope of required accessory components and possible construction needs.
- › Ensure each clinical department has its own equipment succession plan so the enterprise can effectively develop a coordinated approach to fortifying their medical equipment infrastructure while maintaining a harmonized approach to capital spending. ■

## LOOK FOR ARAMARK HEALTHCARE AT THE PODIUM

VISIT ARAMARK HEALTHCARE AT THESE UPCOMING HEALTHCARE INDUSTRY CONFERENCES AND EVENTS:

### The Beryl Institute Patient Experience Conference

April 13-15, 2011  
Southlake, Texas

Jan Moellering, RN, MA, Vice President of Operations, Operations Support for ARAMARK Healthcare, will present a session focused on "Combining Process Improvement and Behavioral Dynamics to Drive Patient Satisfaction."

### 2011 Congress on Healthcare Leadership American College of Healthcare Executives

March 21-24, 2011  
Chicago, Illinois

ARAMARK Healthcare is involved in two presentations:

Anthony Stanowski, FACHE, Vice President of Industry Relations, and Chris Winn, FACHE, Vice President of Administration at Main Line Health's Paoli Memorial Hospital, will co-present an educational session focused on "Hardwiring Service Recovery – Structure and Results." The session will review a case study of Main Line Health System in Pennsylvania, which utilized a Service Recovery program to elevate patient satisfaction scores to the 90th percentile range.



## FIVE TIPS TO MAXIMIZE SUPPORT SERVICES UNDER THE NEW NORMAL

While hospital leaders must remain focused on their core missions of delivering the best possible patient care, support service areas including food and nutrition services, facility services and clinical technology services can contribute to an institution's operational strategy for managing costs and outcomes in the age of reform. The tips below are a few areas to consider when looking to drive value through your support service functions.

### 1. Clinical Technology Services –

Under reform, equipment costs must be lower. Examine your clinical equipment program to determine if your clinical equipment can be extended over a greater period of time or maintained for less money. It is also important to ensure that your next equipment purchase be less costly over its life cycle.

### 2. Food Services and Environmental Services –

Hospitals should forecast food and environmental services based on consistent costs. Expecting cost certainty for food and environmental services, as well as a performance-based relationship that is built on specific quality measures is key for establishing “known” costs.

### 3. Service Consolidation –

Consider consolidating support services under a single provider for greater efficiency. Moody's Investment Services suggests greater revenue opportunities for hospitals through centralized and consolidated support services.

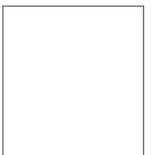
### 4. Workforce Transition –

Evaluate moving support service employees from your payroll to a support service partner's payroll to improve financial outcomes, reduce risk and offer

greater professional development opportunities for employees.

### 5. Patient-Centric Culture –

Drive staff engagement to involve support services as part of the patient care team. The literature suggests that engaged support service staff can contribute to better overall patient satisfaction and quality scores. ■



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