Executive Exclusives

BECKER'S

HOSPITAL REVIEW

February 2016 • Vol. 2016 No. 2

100 Hospital and Health System CIOs to Know

Working to ward off data breaches, lead clinical adoption of IT and continually innovate, CIOs tackle some of the toughest challenges in healthcare every day. Here we highlight 100 movers and shakers in the health IT space this year.

See the full story on page 33.

Johns Hopkins Puts Safety and Quality Data on Display

Public data sharing generates unforeseen benefits

When Johns Hopkins Medicine made performance data public, it hoped to create a culture of accountability, stay competitive and enhance patient relations and resources. It soon found its external-facing dashboards came with a few unintended benefits as well.

See the full story on page 68.

Are Epic and Cerner Healthcare's Apple and Android?

As Epic and Cerner circle in on the lion's share of the EHR market, will they edge out competition, and with it, innovation? We examine this and other key EHR market dynamics through the scope of Apple and Android, two manufacturers who largely rule the smartphone space.

See the full story on page 9.

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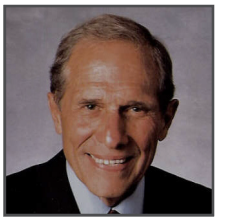

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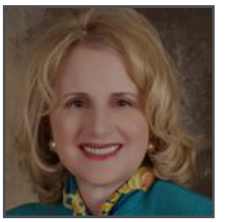

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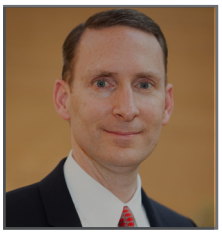

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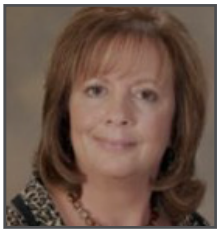

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Publisher's Letter

February Issue. This is the Technology Issue of *Becker's Hospital Review*, featuring a list of 100 hospital and health system CIOs to know. These men and women are leading technology and innovation at some of the largest and most interesting hospitals and health systems in the U.S., and we laud their efforts. The issue also contains three physicians' accounts of what EHRs do well, the stories behind five of the biggest names in health IT — including Epic and Cerner — and 10 startups to know. Read about how Johns Hopkins is using data transparency with its own employees and the public to drive change, and enjoy thought leadership from C. Martin Harris, MD, CIO of Cleveland Clinic, and Ramanathan "Ram" Raju, MD, CEO of NYC Health + Hospitals, among other thought-provoking executives. I hope you enjoy reading.

Becker's Hospital Review 7th Annual Meeting. April 27-30, 2016, at the Hyatt Regency in Chicago. We are thrilled to have some magnificent speakers like George W. Bush, 43rd president of the United States; John Noseworthy, MD, CEO of Mayo Clinic; Chris Van Gorder, president and CEO of Scripps Health; Lloyd Dean, president and CEO of Dignity Health; Joel Allison, CEO of Baylor Scott & White Health; Nancy Howell Agee, president and CEO of Carilion Clinic; Teri Fontenot, president and CEO of Woman's Hospital; Michael Dowling, president and CEO of North Shore-Long Island Jewish Health System; Senator Howard Dean, MD, former governor and chairman of the Democratic National Committee; David Feinberg, MD, president and CEO of Geisinger Health System; Steven Goldstein, president and CEO of Strong Memorial Hospital; Stephen Mansfield PhD, president and CEO of Methodist Health System; and Randy Oostra, president and CEO of ProMedica. It should be a great meeting.

2nd Annual HIT-CIO + Revenue Cycle Conference. July 27-28, 2016, at the Fairmont Chicago. In July, we will again host close to 100+ hospital and health system CIOs and revenue cycle speakers and a keynote panel with coaches Mike Ditka and Bobby Knight, who will diversify the event with some entertaining anecdotes. We hope you will join us.

To learn more and register, please visit: http://www.beckershospitalreview.com/conferences-and-events.html.

Should you have any questions or if I can be of help in any manner, please do not hesitate to contact me at sbecker@beckershealthcare.com. I can also be reached at (800) 417-2035. Thank you, as always, for reading.

Very truly yours,

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8 Thoughts from Cleveland Clinic CIO Dr. C. Martin Harris on Decision-Making and Leadership

By Akanksha Jayanthi

The interconnectedness of healthcare requires individuals to have skills and knowledge of areas and departments outside their specific area of expertise. An *Atlantic* story from 2014 explored the growing trend of physicians graduating from joint MD/MBA programs, noting the number of such programs increased 25 percent from 2011 to 2012 alone. The executive suite is no different, as a number of executive leaders have MD backgrounds, among other advanced degrees.

C. Martin Harris, MD, CIO of Cleveland Clinic, is one of those executives. Dr. Harris holds an MD and an MBA, both from University of Pennsylvania in Philadelphia. In addition to his executive duties, Dr. Harris is a practicing physician, board-certified in internal medicine.

Here, he shared some insight on how his multiple backgrounds contribute to his daily decision-making, as well as what CIOs should keep an eye on in 2016.

Note: Interview has been lightly edited for length and clarity.

Question: You have a long, multifaceted background in both the clinical and business sides of healthcare. What made you decide to pursue both an MD and an MBA?

Dr. C. Martin Harris: I began my career with the intention of becoming an academic physician. I imagined I would split my time between actually practicing medicine and doing research around the macro healthcare questions related to quality, service and cost that might allow me to make a positive impact on the medical practice model itself. To do that work, access to accurate, timely data about the realities of clinical practice is crucial. And, during my research training, one of the first things I realized was that, at that time, access to that kind of real data simply didn't exist. That was because computers were not really used as part of patient care. So at least partially, the shift in my career trajectory from academic research to administrative leadership happened because I wanted to do everything I could to help get the kinds of health information technology systems deployed in the clinical space that would make the research work I originally envisioned possible for future generations of physician scientists.

Q: How do you use your MBA in the day-to-day?

CMH: One of the biggest and potentially consequential challenges in healthcare is driving real value for patients in ways that will keep high-quality care available and affordable for everyone. To address this challenge, we have to start by defining what real value is. In the healthcare industry, we do that by measuring the quality of the care we deliver over the cost of delivering it. My medical education taught me how clinical outcomes and other metrics can reflect care quality. My MBA prepared me to more fully understand the financial and organizational intricacies represented by the cost side of the equation.

Q: What advantages does having formal training in multiple backgrounds provide you? How does being a practicing physician influence the decisions you may make as a CIO?

CMH: My physician training is incredibly important because it grounded me in the practical, demanding activity that is the practice of medicine. That personal experience means that I don't have to try to imagine a clinician's needs; the clinician's point of view is my point of view. It is what I was trained to do. So when it comes to introducing technology into the practice of medicine, I understand the potential workflow or productivity impact of a decision in a way that only someone who manages a clinical practice can. My medical training allows me to see the world through the eyes of a practicing physician; my MBA helps me see how management decisions impact the health of an enterprise made up of many clinical practices and support functions. Both perspectives are important, and being able to see and understand the healthcare world in that way is critical.

Q: As a CIO, what is the biggest challenge you face?

CMH: Probably the biggest challenge for a CIO in a provider organization today involves helping an organization drive to scale, because I think healthcare in the future will increasingly be delivered by organizations who can demonstrate that they deliver quality in a cost-effective way. One way to achieve that is to efficiently increase the scale of the organization in terms of the numbers of patients that can be served while leveraging the economies of scale that can only be understood through a detailed and real-time flow of actionable data. That critical data is really the foundational insight that will inform our future management. As a CIO, creating the infrastructure and integrated systems that will support that work has to be a priority.

Q: How has Cleveland Clinic succeeded in doing that?

CMH: Our administrative leadership team has been actively working to identify and align all the capabilities we need to succeed in a way that is scalable and

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replicable across the organization, making coordinated care delivery through a range of alternative and technology-powered service models a competitive feature of Cleveland Clinic.

Q: What is a lesson you've learned you'd like to share with other CIOs?

CMH: I think one big message that I would emphasize is that while technology can be complicated, a very important service today's HIT professionals can provide to their colleagues in any organization is making technology a little easier to understand. To do that, we need communication. We need to engage with our colleagues regularly and often. And we have to take responsibility for finding ways to help them understand the things about technology that are important to them. That requires real work because it can be really hard to make something look easy.

Q: Looking ahead, what is one thing CIOs should focus on or look forward to in 2016?

CMH: In 2016 and beyond, CIOs should be thinking about bringing new skill sets into their organizations. To me, those skills sets would include business analyst capabilities and enterprise-wide systems design. And by that, I do not mean just information system design. In the 21st century, we must reimagine a healthcare system that will be built upon capabilities and connections that simply did not exist just a few years ago. To envision a new kind of HIT-enabled system of care, we will need people who see the role of technology in a more integrated way.

Historically, the employees in an IT division were only thought of as the people who managed the computers or the network or the data center. In the very near future, the people in your IT division will only spend part of their time working in the division because if they are going to be effective in helping us design better ways to deliver care, they will need to engage with their clinical colleagues directly in their clinical practices. ■

Are Epic and Cerner Healthcare's Apple and Android? 7 Core Thoughts

By Scott Becker, JD, Publisher of Becker's Healthcare

Epic and Cerner, like Apple's iOS and Google's Android, hold the largest market shares in their industry. The Apple iOS and Google Android and their products, branding and ease of use have become so successful that they have few, if any, viable competitors among smartphone manufacturers. Other organizations largely believe they can't compete in the phone operating system business. Epic and Cerner are attempting to put themselves in a similar position for large health system EHRs.

Here are seven thoughts on the positions, similarities and differences between Apple and Android in the smartphone industry and Epic and Cerner in healthcare.

1. Developing a dominant market position. Apple and Android have grown to be so dominant in the phone operating system business that none of their competitors currently stand much chance of gaining a significant foothold in the core market. Nearly 95 percent of mobile phones in the U.S. use Apple's iOS or Google's Android operating systems. Apple and Android were persistent in doubling down on improvements to make their technology so user-friendly that buying phones that don't run on their systems became unattractive for most buyers.

2. Creating a high barrier for entry and edging out competition. As Apple and Android became more attuned to what consumers wanted and made products to match those demands, their growth and market share results skyrocketed. This enabled them to continually refine their operating systems. This cycle cemented the companies' positions and created a higher barrier for entry than had ever existed previously in the mobile phone market. Competitors like Blackberry resolved to build phones for the Android operating system rather than continuing to solely rely on their own operating systems. Additionally, as Apple's iOS and the Google-developed Android system became the standard, more developers introduced applications and programs built to work on these systems. This has created a market space where niche industries have grown alongside Apple and Android and are invested in the success of Apple and Android. This serves to further solidify the position of Apple and Android.

3. Similar strategies at play in healthcare's EHR market. As Epic and Cerner gain more ground in the large-size hospital and health system market, the better equipped they become to serve those systems. As their reach expands, it becomes harder and less attractive for the largest and most influential health systems to not use Epic or Cerner's EHR. Further, the switching costs in EHR are generally huge. As we talk with the largest systems making changes in their choice of EHR, it becomes increasingly clear that they are narrowing their choices. In the past few years, the two health IT titans have begun to cement certain economies

of scale, and their financial success grants them the opportunity to re-invest capital into their own technologies. Cerner's reported revenues for 2014 were $3.4 billion. Epic's reported revenues for the same year were $1.8 billion. However, the lead in size and adoption is not yet anywhere near comparable to that of Apple and Android.

Will they ultimately edge out all competition by refusing to collaborate?

4. Substantial EHR market segments are still open and offer opportunity for others. Epic and Cerner are moving to have the lion's share of the EHR market for large systems. However, there are still gaps and niches in the market that are not saturated with these two companies. There are also several large systems that choose not to use Epic or Cerner. This leaves a great deal of room for other systems to grow. We are seeing growth from companies such as athenahealth and Allscripts, among others, whose focus is also on constant improvement, creating lasting and close customer relationships, and on industry collaboration. Allscripts reported revenues of $1.378 billion for 2014 (and substantial improved EBIDTA) and athenahealth reported revenues of $752.6 million in that same year (a 26 percent growth rate for athenahealth). Both companies and their peers have made significant market share and profit advances in recent years. Paul Black of Allscripts is often highly commended for his leadership as CEO. Zacks Investment Research commends athenahealth's growing physician base, growing product portfolio and investment in research and development.

These other companies have arguably worked to offer more flexibility when it comes to implementation and development than Epic and Cerner. The companies that trail not far behind Epic and Cerner in total revenue also seem to thrive by focusing on specific areas of the market. For example, companies target the physician group market, some large systems as well as smaller health systems and hospitals and niche areas for whom Epic and Cerner's pricing is too steep or whose systems don't prefer Epic or Cerner. They can also in some places offer those systems more flexibility. Thus, some of the other companies are experiencing very significant growth.

5. A core difference between Apple and Android, and Epic and Cerner. Apple and Android very aggressively created a semi-open ecosystem and encouraged companies to build apps for their platform and interact with them. This led to an infrastructure that used their operating systems as a backbone while fostering collaboration and companies to invest with Apple and Android. In many ways, this is quite a different strategy from Epic and Cerner, whose approach is more closed off for both their platforms and businesses. The impact this will have on their success remains to be seen. Are the companies missing a great opportunity to further cement their market share by encouraging other vendors and developers to design technologies capable of using their existing infrastructures, or will they ultimately edge out all competition by refusing to collaborate?

6. All four companies are led by driven, visible CEOs. Judy Faulkner, founder and CEO of Epic, has proven to be just as headline-grabbing as the company she steers. Ms. Faulkner is a self-made billionaire and one of the richest women on the planet – she designed the original software that Epic is built on and has guided the company in its steady growth since 1979. Neal Patterson, CEO of Cerner, also co-founded his company in 1979. He is known for his direct, hands-on leadership style. These two powerful figures, in many ways, mirror the big personalities leading their cross-industry counterparts. Steve Jobs is one of the most well-known CEOs ever. He was a public figure and represented the ideas that Apple set forth as much as he did the company itself. Larry Page, CEO of Google before becoming CEO of Alphabet in July, helped build a company credited with one of the most unique management styles and cultures.

7. Core business lessons. Reinvest and Double Down on Market Position. There are important business lessons learned by comparing the rise of these companies in their respective markets. First, as one develops a great or dominant market position, they must make a serious commitment to reinvesting to improve their products and performance. Epic particularly prides itself on its spending on research and development. Second, Apple and Android opened up the platforms they built for third parties to use as a jumping-off point. This helped further strengthen their dominant market positions. Third, Apple and Android kept pricing for their services and products reasonably high, which allowed them to make substantial profits and also have money to reinvest. However, the pricing is not so high as to suppress demand. It is not clear if Epic or Cerner will be able to match this pricing concept. ■

The Upside of EHRs: 3 Physicians on What They Get Right

By Max Green

EHRs are healthcare's most popular punching bags. Physicians say the clunky, unintuitive interfaces make their jobs harder. The cost of implementation ranges from hundreds of thousands to millions of dollars, with some systems even planning for $1 billion-plus. Patients also have a problem with EHRs: The more time the physician spends entering data and looking at a screen, the less satisfied patients become, studies suggest.

With complaints as rich as these, it's easy to overlook the good EHRs facilitate. Here are three perspectives from physicians on what EHRs have gotten right.

Note: Responses have been edited for clarity, style and length.

Jesse Ehrenfeld, MD

Associate Professor of Anesthesiology, Surgery, Biomedical Informatics and Health Policy at Vanderbilt University School of Medicine (Nashville, Tenn.)

Board Trustee for the American Medical Association (Chicago)

"EHRs are obviously here to stay for a lot of reasons, and there are certainly very positive things about them. I think about the things they let me do very effectively, and the things I think most practices around the country that have adopted them find useful. Primarily, they fall into three categories. I think there have been a lot of benefits around e-prescribing. Secondly, some of the drug alerts and clinical decision support built into EHRs have helped us improve quality and safety. Then the ability of multiple clinicians or users to access medical information at the same time. These are probably some of the biggest benefits that, across specialties and practices, physicians find really helpful.

In the operating room, when I have a patient who is under anesthesia, the electronic record gives me a visual representation that allows me deeper insight into what's happening in the moment. When I talk to my colleagues that have clinic-based practices, they find the same thing. Having a longitudinal view of data pulled together in a way that generates information is probably a huge benefit of these systems. The challenge, of course, is doing that right and well. The AMA has laid out principles around how these things can be best done, and one of the principles is these systems should help reduce cognitive workload and get better insight from information in the patient's record."

Anas Daghestani, MD

Internist at Austin (Texas) Regional Clinic

"We've pulled all of the clinical data out of our EHR and combined it with claims data from insurance. That allowed us to have more of a complete picture about what happens within and outside our system. We then looked at our population to see how we compared to the National Committee for Quality Assurance guidelines on different health measures, like cancer screening, management of diabetes and management of coronary artery disease. That allows us to look for areas where we're doing better and worse, and devote resources, education and awareness on a system level. At the individual level, we've built alerts within the system to alert our physicians at the time of the [patient] visit. So if I have a patient seeing me for an ankle sprain, but they haven't had a colon cancer screening test done in 10 years and they're due for one, it's going to give me an alert within the system.

We've built those same alerts on the patient side. Our patients have access to our portals, so we've invested a lot of time and energy into promoting access to our system on the patient or customer side so they can log in and see this information the same way we're seeing it. If I'm a patient at Austin Regional Clinic and I log in, it will show that I'm due for a pneumonia shot or a flu shot, that I'm overdue for a mammogram or a colonscopy or a blood test. Making that information available to the patient on an individual level and the physician on a system level measures how we're doing between different providers, different locations and on a population level. We can then decide how we want to invest our resources.

We saw we were having a hard time with screening diabetic [patients] for eye disease. [Screening] rates were low. We looked at national rates and found them to be as low as ours, so we invested in technology and solutions. We ended up bringing screening equipment in-house, so screenings could be done in the lab at the same time that a patient gets a blood test. We began seeing a dramatic improvement in our screening rate immediately. Before the EHR, we would have not been able to measure that information."

Monica Williams-Murphy, MD

Emergency Medicine Physician at Huntsville (Ala.) Hospital

"EHRs are going to be part of the solution for having accessible and actionable advance directives. Medical care can be driven by wisely considered patient wishes, particularly near the end of life when patients are often unable to speak for themselves. The era of paper records and paper-based living wills [or] advance care plans will hopefully, sooner rather than later, give way to a much more cohesive care plan informed by patient wishes." ■

The Stories Behind 5 Health IT Company Names

By Max Green and Carrie Pallardy

Health IT is an industry with many big names, but where do they come from? From the Greek gods to a love affair with language, here is the history and inspiration behind five household names in health IT.

athenahealth (Watertown, Mass.)

Meaning: The name 'athenahealth' can be traced back to a clinic co-founded by Jonathan Bush, now CEO of the company, and Todd Park. The clinic's name was derived from the Greek goddess Athena.

What leadership has to say: "The name athenahealth is an homage to Athena Women's Health, the birthing clinic Todd Park and I founded in San Diego, to reinvent the childbirth experience with more midwives, more focus on mothers and best practices driven by statistics. We named the clinic after the Greek goddess Athena, who symbolizes wisdom, inspiration and courage. Our goal was to produce better clinical outcomes and a superior experience for mothers at a lower cost. We accomplished the first two, but couldn't get a handle on our revenue cycle. That eventually led us to try to fix the billing process for other practices in our situation…and the health IT company athenahealth was born," says Mr. Bush.

Cerner (Kansas City, Mo.)

Meaning: Cerner, originally named PGI, was founded by Neal Patterson, Cliff Illig and Paul Gorup in 1979. In 1984, the company assumed its current — and now widely recognized — name. The company's founders drew on several Romance languages to find a name they felt to be more meaningful. Cerner can be traced back to the Latin word "cernere," which has meanings including "to separate," "to sift" and "to discern." In Spanish, "cerner" can mean both "to sift" and " to blossom."

What leadership has to say: "The meaning of the name is aimed right at the heart of what we do as a clinically focused IT and healthcare company. In the 1980s, it was all about helping clinicians access the mountain of information generated by healthcare processes to find the most relevant information. Fast forward three decades and the sphere of scientific, clinical and even patient-generated data has only grown larger. There's a world of big data, and it's our job to create solutions that sift through it at high speed and shine a light on what is truly meaningful and valuable to improve health," says Zane Burke, president of Cerner.

CommonWell Health Alliance (Boston)

Meaning: CommonWell Health Alliance's name can be broken down into four parts. "Common" relates to the shared, standard services providers and patients could use to access health data. "Well" is a nod to the organization's efforts to help patients stay well. "By connecting those two words, we were ensuring that we always ensured the patient and their well-being were at the center of our services," says Jennifer Smith, marketing chair of CommonWell Health Alliance.

She continues to say "Health" and keeping people healthy is, again, the underlying goal of the organization. "Alliance" refers to the group of members who share the organization's mission and encapsulate the group's values of partnerships, transparency, accountability, inclusiveness and integrity.

What leadership has to say: "CommonWell Health Alliance was formed as a collaborative effort of health IT vendors who shared a similar vision of improving the delivery of healthcare through interoperability across disparate providers, organizations and geographies," Ms. Smith says. "As such, we looked to create a name that represented our shared vision and work effort to keep people healthy and help patients get well when they did get sick."

Epic (Verona, Wis.)

Meaning: Epic founder and CEO Judy Faulkner wrote the underlying software infrastructure for the major EHR company in the mid-1970s. At the time she was a programmer who had developed a clinical data management system; she had no plans to start a company. But, her clients had different ideas. After repeated requests, Ms. Faulkner agreed to create a company around the system she had developed. During a preliminary meeting at her home, one of the company's original clients pulled a dictionary off the and shelf looked up the definition of "epic": "the glorious accounts of a nation's events." The group liked the name, and it would be the story of a patient, not of a nation. Though the system has evolved to include not a single line of the original code, the Epic name endures and remains one of the most talked-about companies in health IT.

What leadership has to say: "I think [the name] is perfect. It is an Iliad or an Odyssey; it is the story of the patient," Ms. Faulkner says. "When we had a lightweight version of Epic we called it Sonnet. The tablet version was named Canto, the smartphone version is named Haiku. We are keeping the literary theme alive. I was a math major in undergraduate school and computer science major in graduate school, but during my undergraduate time I was an English minor. I think it is important that computer scientists can be seen as literate, too."

Nuance (Burlington, Mass.)

Meaning: Nuance Communications began with a focus on speech recognition and language understanding technology. The name signifies the technology's ability to understand the nuances, such as context and intent, in the language people use when communicating.

What leadership has to say: "It's the subtlety of language and expression, something we specialize in at Nuance, that provides the accuracy of our solutions and ease of use for our customers," says Ann Joyal, director of corporate communications for Nuance's healthcare division. "We understand the 'nuances' between how people communicate, whether they are physicians who use special medical vocabularies to dictate long patient notes or a consumer using a smartphone to ask for the nearest coffee shop." ■

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Breaking Up is Hard to Do: 6 EHR Vendor Switches in 2015

By Akanksha Jayanthi

There are any number of reasons for hospitals to switch EHR systems. Providers may seek different functions and capabilities, or mergers and acquisitions may require an EHR change to keep all hospitals on the same platform.

According to ONC data presented in September, more eligible hospitals participating in meaningful use changed their EHR vendors in 2014 than in previous years. Four percent of attesting hospitals changed EHRs in 2014, while none did in 2013 or 2012.

In 2015, *Becker's Hospital Review* reported nearly 60 EHR contracts and go-lives. Here are six that required a switch in vendors.

1. Mayo Clinic: From Cerner and GE to Epic. In January, Rochester, Minn.-based Mayo Clinic announced plans to adopt Epic's EHR and revenue cycle management platform and drop its contracts with Cerner and GE. Mayo Clinic CIO Cris Ross told Healthcare IT News the system sought request for proposals from Cerner, GE and Epic and ultimately decided Epic would best meet its needs around revenue cycle and patient engagement.

2. Banner Health: From Epic to Cerner. Phoenix, Ariz.-based Banner Health decided in September to replace Epic's EHR system at its two Tucson hospitals — Banner-University Medical Center Tucson and Banner-University Medical Center South — with Cerner's platform. The two hospitals adopted Epic's EHR when they were part of the former University of Arizona Health Network. Banner acquired the health network in March and decided to switch the hospitals to Cerner, as the rest of the Banner's 28 hospitals use Cerner's EHR.

3. Middle Park Medical Center: From Healthland to Epic. Middle Park Medical Center in Kremmling, Colo., plans to implement Epic's EHR and replace its current Healthland EHR. The hospital partly selected Epic because its managing company, Englewood, Colo.-based Centura Health, is also in the process of transitioning to Epic's EHR, and MPMC will implement Centura's Epic software. (Centura decided in 2014 to switch from MEDITECH to Epic, and go-lives are scheduled to begin May 2016.) Meeting minutes for an Aug. 27, 2015 board of directors meeting at MPMC state, "The Senior Leadership Team has agreed that Healthland is a disaster and we can't wait." According to a Ski-Hi Daily News report, Healthland's software hasn't been updated since 2008.

4. Southcoast Health: From MEDITECH to Epic. In October, New Bedford, Mass.-based Southcoast Health went live on Epic's EHR. The system previously used MEDITECH's EHR platform, according to The Herald News. Keith Hovan, president and CEO of Southcoast Health, said in a statement that having Epic "puts us in good company with top healthcare providers across the nation who have also chosen to go with this leading EHR system."

5. FirstHealth of the Carolinas: From McKesson to Epic. Pinehurst, N.C.-based FirstHealth of the Carolinas plans to switch from McKesson's EHR platform to Epic's EHR platform. FirstHealth CEO David Kilarski said in memo to employees that Epic provides "a single electronic record of a patient's entire medical history" and will be important to patient health management, reports Southern Pines Pilot. FirstHealth announced the EHR selection in August.

6. IASIS Healthcare: From McKesson to Cerner. Franklin, Tenn.-based IASIS Healthcare, an owner and operator of acute care hospitals, currently uses McKesson's EHR but in November announced plans to switch to Cerner's platform. "Cerner is well established with other health organizations in our regions, which will benefit providers across the continuum of care as they strive to make informed health decisions based on patients' complete health records," said IASIS CIO Brian Loflin. ■

Note: This list is not exhaustive.

> **"The Senior Leadership Team has agreed Healthland is a disaster and we can't wait."**
>
> *– Middle Park Medical Center board meeting minutes, on switching to the Epic EHR from Healthland*

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10 Startups to Know for 2016

By Max Green

Bright minds from a variety of backgrounds are teaming up across sectors to grow startup businesses. In healthcare, the stakes for these young companies are often higher and the challenges are more robust.

The number of startups operating within healthcare has exploded, growing 200 percent from 2010 to 2014, according to *Forbes*. Startups' funding increased by 125 percent from 2013 to 2014, according to Startup Health, a New York City-based accelerator. Some are backed by angel and seed investors, some are the products of high-profile incubators and others boast a more fledgling background. Tasked with creating solutions to problems that are complex and high-stake, these teams marry clinical, engineering and design expertise.

Here are 10 startups that have gotten off to a running start with big plans for the year ahead.

1. Everseat (Baltimore). The day of a medical appointment, any number of things can go wrong. It's not uncommon for traffic, weather and other hang-ups to get in the way of making it to an appointment on time, and life's curveballs often result in cancellations. Everseat offers a web- and mobile-based platform that aims to overcome these unexpected scheduling snafus. The ability to make appointments directly from a smartphone is a boon for both patients and providers, says Andy Tarsy, senior vice president of strategy and business development. Patients are empowered to find appointment times that work based on their availability and the locations and types of physicians they want to see. They are also notified in advance if there will be substantial wait times or delays. At the same time, physicians using the app are able to reduce scheduling "waste" and lost revenue opportunities. In October 2015, Everseat partnered with athenahealth's More Disruption Please program to allow athenahealth's physicins to offer the apps' capabilities to their patients.

2. PatientPing (Boston). What if every time a patient stepped into any kind of facility seeking care, your organization received a notification, much like a you'd receive a text message or email? This is the future that Boston-based PatientPing wants to make a reality. The company is in the process of creating a national care coordination network that "pings" participating organizations in real time when patients they know are admitted or discharged. The "ping" includes care team contacts, patients' locations and access to critical guidelines. The PatientPing network currently includes facilities across Massachusetts, Pennsylvania, Connecticut and Michigan. The company recently secured $9.6 million in a funding round led by Google Ventures and plans to use this capital to expand its employee base and services.

3. Nightingale Apps (Boston). Developer Nightingale has created and begun testing an app aimed at a sometimes-overlooked part of the care team, but one that has a huge impact on patient outcomes and satisfaction: Nurses. The Know My Patient app offers workflow-specific modules that give nurses and other frontline care workers up-to-date patient information, synced in real time with a hospital's EHR. This frees them from having to return either to handwritten notes or a computer hub to look up information or answer questions. "All of our efforts made since the company's inception [in 2013] have prepared us to launch Know My Patient with testing partners in 2016 and subsequently grow our client base to create an impact in driving safer, more efficient and cost effective care," says Tiffany Kelley, PhD, the company's founder and CEO.

4. DispatchHealth (Denver). There are a number of startups vying for the much-buzzed "Uber for healthcare" title. DispatchHealth may be one to claim the name. DispatchHealth offers mobile, onsite treatment for simple and complex patients needs. Using its app, customers can summon a clinician to come administer care wherever they may be. The company boasts longer, cheaper visits with providers and shorter wait times than traditional visits. "Bringing the house call back with a modern twist was something we felt we had to do," Kevin Riddleberger, chief strategy officer and cofounder of DispatchHealth, told *Becker's Hopsital Review* in an October interview. Mr. Riddleberger says DispatchHealth is positioned to address major industry pain points, such as the primary care physician shortage, millions of unnecessary 911 transports and potentially avoidable admissions.

5. Healthfinch (Madison, Wis.). Physicians increasingly spend time on computers and with EHRs. It only makes sense to try to safely automate as many time-sucking tasks as possible, and Healthfinch designed a solution for one of those processes: prescription refill requests. So far, more than 1,800 physicians use Healthfinch's software, and hospitals and practices report saving 15-30 minutes of physicians' time per day. Additionally, many have been able to redistribute the efforts of full-time RNs, whose tasks revolved around handling prescription refills. In a November interview with *Becker's Hospital Review*, Healthfinch CEO and cofounder Jonathan Baran hinted the company has its eye on a number of other processes and workloads it hopes to improve via automated solutions.

6. HoneyInsured (Boston). It all started for HoneyInsured when cofounders Grace Gee and Eugene Wang, two Cambridge, Mass.-based Harvard math undergraduates at the time, wrote about a troubling health insurance marketplace trend they'd come across in the journal *Technology Science*. The students found rising premiums did not seem to correlate with increased consumer benefits and, between 2014 and 2015, the largest insurance companies in 34 states increased premiums by more than 75 percent compared to smaller insurers. Their solution is the HoneyInsured website, which integrates with HealthCare.gov's

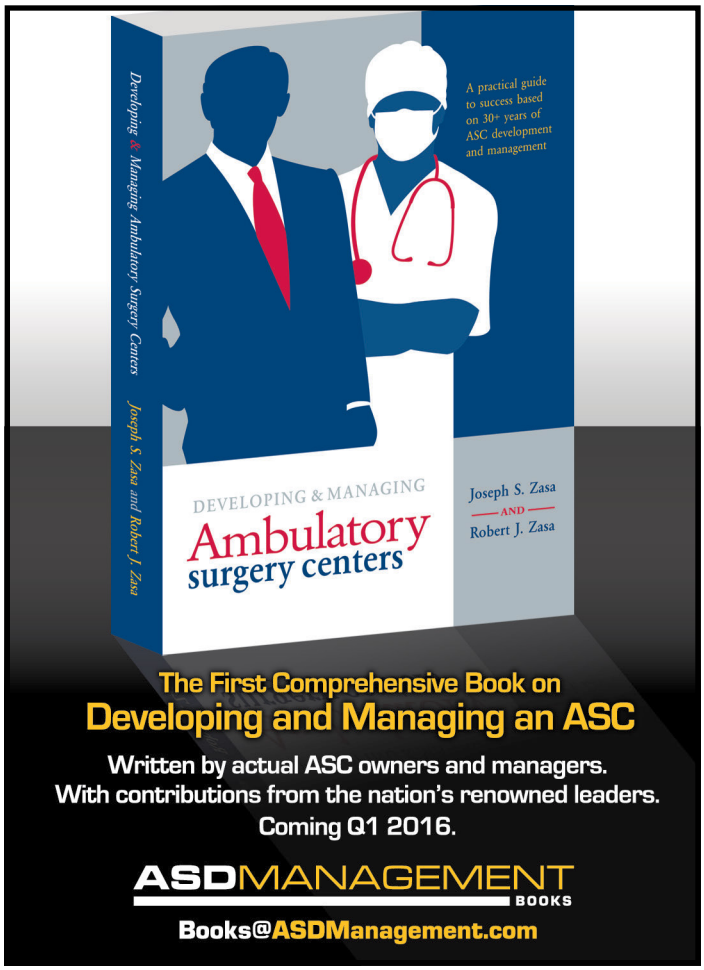
application program interface and acts as a "web broker," enabling consumers to order insurance like they would if they applied using the official federal exchange site. HoneyInsured aims to take the guesswork and confusion out of the process for the millions of consumers signing up for healthcare coverage through HealthCare.gov by intaking their information and making unique plan recommendations, offering data visualization and personalized options based on user input.

7. Hospital IQ (Newton, Mass.). As hospitals grapple to find the right tools for analyzing large amounts of data, the best solutions are likely those that work using the IT systems currently in place and data that's already on hand. Hospital IQ is one of those solutions. The company aims to bring an end to cluttered spreadsheets and overly technical data points by designing methods of data analysis stemming from accessible operations science. "The company's data-driven solutions apply proven operations research to systematically optimize capacity, schedules and staffing at hospitals," says Rich Krueger, founder, president and CEO of Hospital IQ. In 2015, the startup signed on customers like Brigham and Women's Hospital in Boston and Jefferson University in Philadelphia, and now has active pilot programs at hospitals in California, Connecticut, Florida, Maryland, New Jersey, New York and Tennessee.

8. CrowdMed (San Francisco). Crowdsourcing a diagnosis may sound risky at first — unless the crowd you query is made up of physicians. Jared Heyman, founder and CEO of CrowdMed, found this to be true after his sister had the rare opportunity to meet with a large team of medical experts who helped solve a mystery condition that plagued her for years and cost more than $100,000. CrowdMed, which links patients whose conditions elude diagnosis with a team of medical detectives who seek answers from experts, was Mr. Heyman's idea to provide a similar opportunity for people wrestling with chronic mystery conditions who may not have the same opportunity his sister did. Through CrowdMed, patients submit their cases for a flat fee — $149 for a "standard" package, $249 for "premium" and $349 for "priority" — and receive their money back if the company can't deliver an accurate result. Experts earn points for cases they help solve, which translate to improved ranking, recognition and in some instances financial compensation. "Earlier this year we carried out a crowdfunding campaign on Indiegogo for patients who can't afford a CrowdMed case," says CrowdMed founder and CEO, Mr. Heyman. "Our goal is for every person in the world with an unsolved medical condition to have access to CrowdMed's services."

9. Zest Health (Chicago). An increased drive toward patient engagement due to increasing consumer costs and higher expectations for quality care experiences might rally patients' concerns about their health, but it doesn't necessarily provide them with the tools to make informed decisions. Smart Concierge, an app-based solution designed by Zest Health, aims to provide patients with those tools. The app offers the expertise of RNs who are on demand to offer personalized guidance, allows users to find and book appointments with in-network providers and includes simplified benefits information. "We wanted to give folks the access, guidance and information they needed to be more intelligent healthcare consumers," Shawn Ellis, president of Zest Health, told *Becker's Hospital Review* in an October interview. "Hence our motto: 'Be Smarter, Buy Better.'" Mr. Ellis views Smart Concierge as a "human-powered technology," which gives users the tools to better understand and take control of their care.

10. SmartScheduling (Boston). Not all hackathons produce winning ideas that blossom into successful startups. But in 2012, a hackathon hosted by the Massachusetts Institute of Technology did just that. It was there that Chris Moses would overhear an exchange between two physicians that crystallized a problem many others wanted solved: Patient no-shows. He founded Smart Scheduling in 2012. The company, which he now heads as CEO, teamed up with athenahealth's More Disruption Please program quickly thereafter, raised over $1.1 million to date and established a network of more than 600 providers across 25 states who use its algorithms to better schedule patients. Remarkably, the company has done all this with just eight employees. "The biggest next step for us is that athenahealth is beginning to bundle Smart Scheduling into new customer implementations," Mr. Moses told *Becker's Hospital Review* in a November interview. "Certain providers will have [the platform] integrated into their EHR." ■



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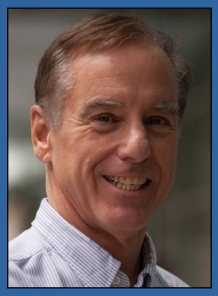
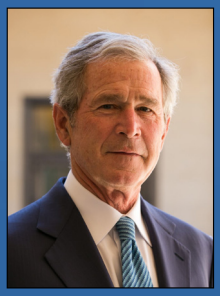
Nancy Howell Agee
President and Chief Executive Officer, Carilion Clinic (Keynote Panelist)

Joel Allison
Chief Executive Officer, Baylor Scott & White Health



Howard Dean
MD, Former Chairman, Democratic National Committee and Governor of Vermont (Keynote Panelist)



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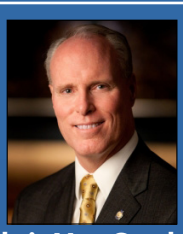

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John Noseworthy
MD, President and Chief Executive Officer, Mayo Clinic

Quint Studer
Founder, Studer Group

Teri Fontenot
FACHE, President and Chief Executive Officer, Woman's Hospital (Keynote Panelist)

Session Tracks

- **Track A** - CEO, Strategy and ACO Issues
- **Track B** - ACOs, Population Health, Affiliation and Other Issues
- **Track C** - Physician-Hospital Alignment
- **Track D** - Patient Safety and Quality Issues
- **Track E** - CFO and Financial Issues
- **Track F** - Revenue Cycle Management Issues
- **Track G** - Health Information Technology Issues
- **Track H** - Thought Leaders

KEYNOTE PANELISTS

Barry Arbuckle
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Peter Butler
President, Rush University Medical Center

Michael Dowling
President and Chief Executive Officer, North Shore-Long Island Jewish Health System

Steven Goldstein
President and Chief Executive Officer, Strong Memorial Hospital

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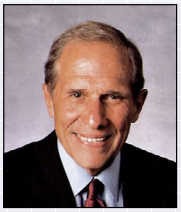

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Epic's Young Physician User Base: What Does This Mean for the Future of EHR Vendors? 10 Takeaways

By Akanksha Jayanthi

Looking at the demographics of a vendor's client base can provide insight into the EHR market share, potentially even hinting at which vendors are positioned for continued growth.

A new research report from Wells Fargo Securities combines data on physician EHR users and their demographics to estimate the average age of the client base for 10 of the largest EHR vendors.

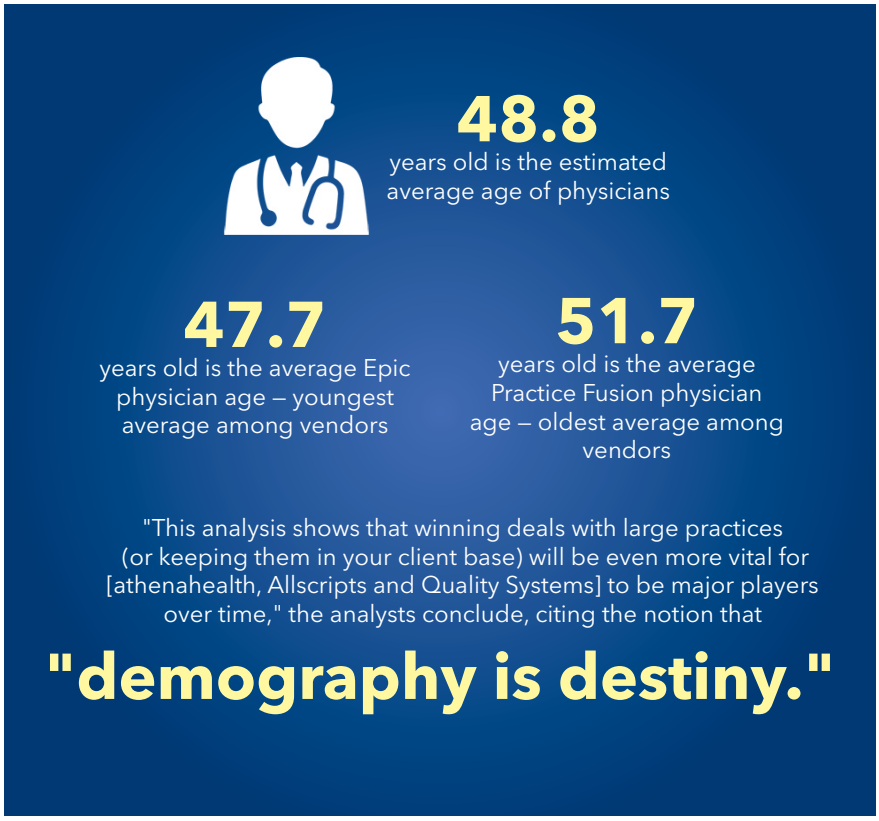
Here are 10 things to know about the analysis.

1. The average age of physicians using an EHR is estimated to be 48.8 years old.

2. The majority of vendors' clients are estimated to fall right around this age, from GE Healthcare (48.1 years old) to eClinicalWorks (49.3 years old).

3. In between those vendors are Cerner, NextGen Healthcare, athenahealth, Allscripts and Greenway Health, all with users around an average age of 48.7. McKesson users share a slightly higher-than-average age of 50.4 years.

4. What stands out are the two vendors on either end of the spectrum, whose average physician age is estimated as lower or higher than their competitors. Epic's average physician age is 47.7 years old, the youngest average among vendors. Practice Fusion's is the highest, at 51.7 years old.



5. These results are contrary to what the analysts expected. "We thought this analysis might indicate more web-based software like [athenahealth] among younger physicians, but no," they wrote. (athenahealth's average user age is 48.9 years old, right in line with the overall average age.)

6. Epic's relatively young user age suggests the vendor is solidifying its leading position in the EHR market for years to come. After all, the analysis shows Epic has held more than 25 percent of the market share among physicians who graduated from medical school in the past 15 years.

7. This growth in market share could be tied to the growing numbers of physicians seeking employment in larger groups at the beginning of their careers, according to Wells Fargo analysts. The report states "those larger groups have disproportionately implemented Epic (and continue to do so)."

8. The vendor with the second highest market share over the past 15 years is Allscripts, whose market share hovered right around 10 percent but has been declining since 2005.

9. As for Practice Fusion's higher-than-average age cohort, analysts suggest older physicians are drawn to this vendor because it is free, and these physicians may not be as interested in investing in software as they approach the end of their careers.

10. "This analysis shows that winning deals with large practices (or keeping them in your client base) will be even more vital for [athenahealth, Allscripts and Quality Systems] to be major players over time," the analysts conclude, citing the notion that "demography is destiny." ■

Health IT Professionals Think They're Underpaid

This and 9 More Findings on IT Salaries

By Akanksha Jayanthi

How much money is adequate for health IT professionals? According to a recent survey by HealthITJobs.com, many health IT professionals' actual salary is significantly lower than their desired salary.

The survey gathered responses from more than 700 health IT workers. Here are 10 key findings on health IT salaries from the survey.

ONE The average health IT salary in 2015 is $87,443, and the average bonus is $7,990.

TWO Contracted workers reported an average salary of $91,241, and full-time employees reported an average salary of $86,156.

THREE However, the average desired salary among survey respondents was $105,631, a significant gap of approximately $18,000 from the average.

FOUR One-third of respondents reported receiving a bonus.

FIVE The survey found previous experience in health IT is more valuable – and translates into higher salaries. For example, respondents with prior health IT experience reported an average salary of $89,242, while respondents without prior health IT experience reported an average salary of $54,238.

SIX Similarly, having IT certifications translates to higher salaries. Those with a certification reported an average salary of $95,689 and those without reported an average salary of $82,367.

SEVEN Though a gender gap still persists, it was much smaller in 2015 than previous years. In 2014, males made approximately $17,832 more than women, while in 2015 the gap shrunk to $1,185.

EIGHT Here are the average salaries for five key job roles.

- -Project manager: $107,674
- -IT management: $94,275
- -Business intelligence: $81,574
- -Healthcare informatics: $80,907
- -Implementation consultation: $78,147

NINE Salaries also vary geographically. IT professionals in New England are on the higher end of salaries while those in the Midwest are at on the lower end.

- -New England: $99,536
- -Mid-Atlantic: $97,620
- -Mountain: $97,381
- -Southeast: $91,239
- -Pacific: $90,401
- -Southwest: $90,259
- -Midwest: $80,311

TEN Average salaries by organization type also fall along a wide range. Those with consulting companies report average salaries of $107,281; IT professionals at hospitals and health systems report $87,758; those at software vendors report $85,512; those at physicians groups report $85,094; and those at clinics report $76,884.

IT Underused in Population Health Initiatives, Study Finds

By Akanksha Jayanthi

While the healthcare industry is doubling down on population health efforts as it works toward the triple aim, a study from HIMSS found few organizations use health IT tools to assist in these efforts.

The study gathered insight from approximately 200 healthcare executives on their population health initiatives. Two-thirds of respondents said their organizations currently have population health initiatives in place. Most of these initiatives focus on chronic disease management (83 percent of organizations with current initiatives) and wellness and preventive health (82 percent).

However, the study found just 25 percent of organizations with initiatives in place use a specific IT vendor solution for their population health efforts.

The HIMSS report suggests key areas where a vendor-provided solution could aid organizations in their population health initiatives, including business intelligence and analytics, data warehouse and aggregation and patient dashboards.

Of those organizations without current initiatives in place, more than half plan to start one, but there remains "a high level of uncertainty" about using a vendor solution, according to the study. ■

The CIO's Role in Cost Improvement

By Liz Kirk, Senior Vice President, Cost Improvement, Strata Decision Technology

For the last decade, CIOs have been consumed with implementing and gaining adoption for EHRs. Now that they are implemented and widely adopted, we've arrived in the "post-EHR era" — and the CIO's role is shifting.

Now, the CIO's main responsibility is to make all of the data collected day in and day out throughout an organization accessible to decision-makers in an actionable, meaningful and user-friendly format. As the pace of change and degree of risk increases for providers, the need for quick, data-driven decisions grows. Getting data in the hands of operational and clinical leaders will enable improvements in quality, cost and strategy. Whether it's at the bedside or in the executive offices, it is the CIO's duty to get the right information to the right people to provide quality care and make timely, well-informed decisions so the health system runs as effectively and efficiently as possible.

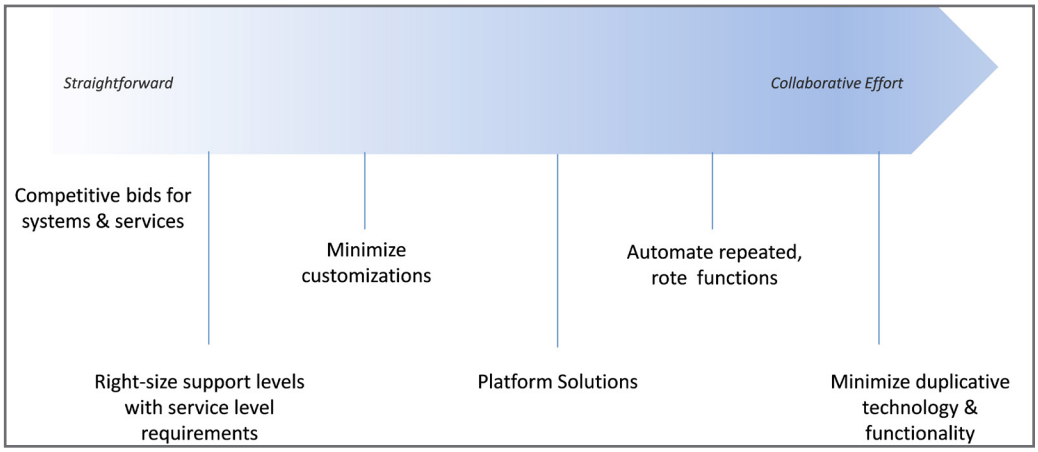


Exhibit 1

The CIO must be aligned with the strategic priorities of the C-suite. According the annual American College of Healthcare Executives survey, for the 11th year in a row, "financial improvement challenges" topped the list of CEO concerns for 2014, the most recent year available. Not surprisingly, it also tops the list for CFOs, according to several recent surveys.

While CIOs haven't traditionally been financially focused, they are now key players in the cost improvement conversation. The CIO has two vital responsibilities specific to driving out costs: stewardship of the organization-wide IT spend and enabling cost savings initiatives to produce real savings. If a CIO is not viewing his or her role in this way, the organization is undoubtedly *not* realizing all of the savings available to them.

Stewardship of the IT spend

As healthcare providers become increasingly technology enabled, the opportunities to spend more money on systems, implementation, maintenance fees, networks and consultants are endless. However, the IT stack can quickly become fraught with duplicative systems and functionality — *read "excess cost."*

After years of cost reduction in front-line operational and clinical areas, it is necessary to look beyond these areas to generate the level of cost savings needed. The CIO should lead the charge to reduce the cost of IT operations.

As shown in Exhibit 1, CIO-related cost savings opportunities run the continuum from straightforward just-do-it actions to the more complex initiatives that require cross-functional collaboration and well-defined processes and structures.

The power of the platform in reducing cost

One cost savings opportunity that falls directly within the CIO's domain and cannot be overlooked is the *power of the platform*. Oftentimes, operational, financial or clinical leaders find a system they want that meets their particular needs. But to either feed this system data or use the output of this system, many manual processes are spawned. Smart people become the *duct tape* that tenuously holds the systems together.

Take the finance operations of a large, academic health system. They have one system for financial decision support, one system for clinical decision support, another system for budgeting, another for long-term financial planning, and yet a fifth system for capital planning and tracking. There are countless manual, offline processes in which a person is critical to moving data from one system to the next. Essential operational reports are routinely run in Excel because no single system supplies the information operational leaders need to manage their department.

Unfortunately, the complexity in this health system is not unique. In fact, it's quite the norm.

It is the CIO's responsibility to provide end users with a better, more efficient, less error-prone process. In the example above, efficiency can be drastically increased by replacing disparate systems with a single platform that provides that functionality all in one.

Reducing customizations

How many times have you heard people in your organization say "we have to customize it to make it work for us" when implementing new systems?

Customizations typically result in higher implementation fees, longer implementation cycles, slower processing times, more support needs, more unplanned downtime and difficulty in upgrading functionality. While it can be difficult to accept off-the-shelf functionality, balancing customizations with standard or supported configurations can result in long-term cost avoidance.

It is the CIO's role to help operational and clinical leaders understand this truth and weigh the costs and benefits of requested customizations. Doing so will promote long-term satisfaction with the system.

Simplifying the IT stack to get greater functionality

Having a well-defined methodology for reviewing the existing IT stack and proposals for new systems is an essential CIO duty. The process should include clinical, operational and financial leaders.

Following the DIME method (Exhibit 2) is one example of a rigorous methodology that helps an organization simplify and streamline both existing technologies and evaluate new technologies.

The CIO should require the staff requesting new systems or significant investments in existing systems to provide a business case outlining why the technology is important and the expected ROI on the investment. Clarity and transparency about IT requests, including the expected benefits, allows senior leaders to prioritize how scarce dollars are allocated to produce the highest organizational value. Once systems are implemented, the CIO's office should lead a rigorous look-back analysis comparing the forecasted ROI with the realized ROI.

It is equally important for the CIO to partner with operational, clinical and financial leaders as they work to identify and implement cost savings opportunities.

Duplicative Functionality	**Innovative Functionality**
Does this functionality exist in another system? ACTION • Select a single system with the greatest native functionality • May require enhancing features in the selected system	Does this system offer new, valuable functionality? ACTION • Develop a business case • Weigh ROI v. investment v. benefit
System Maturity	**Existing System or Platform**
Where is the system on the maturity scale? ACTION • Evaluate if the system is meeting needs and if the vendor is continuing to invest in and enhance the product • Eliminate systems that are not meeting needs	Does the organization already have modules from this vendor? ACTION • Evaluate if there are productivity and functionality benefits to be gained by continuing to invest in the platform rather than going with a best of breed system

Exhibit 2

Promoting self-service access to actionable information

Getting useful, drillable, actionable data into the hands of decision-makers is the most impactful endeavor a CIO can take on. When end users have to go through gatekeepers of information to get data, the pace of change slows dramatically and often comes to a complete standstill. Up until recently, these gatekeepers were instrumental because accessing large amounts of data required deep expertise in writing queries and understanding data structures. However, with the introduction of more user-friendly decision support systems and presentation layer software that sits on top of core systems, many end-users can competently access the data they need to make decisions without gatekeeper assistance.

Providing access to self-service data sources and analytical tools will make an organization more action-oriented, data-driven and focused on metrics that matter.

Overcoming 'integration infatuation'

Integration infatuation occurs when recently affiliated organizations make do with substandard or inaccurate information and inefficient processes for their combined entities because they are waiting for the same systems to be adopted throughout. This can take years. In the meantime, manual analyses and unwieldy reports are generated by over-taxed teams. Decision-making and progress on important initiatives stall.

The CIO plays a key role in providing a bridge strategy and technologies that enable business leaders to get the information they need — despite the disparate systems — without waiting for years. Technology can pull the same type of data from different systems, normalize it and then make it available for combined reporting and accessible to decision-makers. Major functional areas, such as billing and financial reporting, can be combined easily and the goal of achieving cost savings through affiliating can be realized sooner.

Recognizing the need for niche technology

Despite huge investments in EHRs, new billing systems and enterprise resource planning systems that promise to fulfill virtually all data and process needs, there are niche technologies that go far beyond the off-the-shelf functionality of large, all-purpose vendors. These niche technologies provide sizeable ROIs. For example, there is technology available that sits on top of the core billing system and automates over 50 percent of the tasks that billing staff do on a daily basis — and with greater consistency.

There is also technology available that runs algorithms to find cost savings across an organization and presents these findings in a way clinical and operational people can easily understand and act on, thus minimizing the need for an army of analysts to do math. It is this type of functionality that can truly change the tenor of an organization. Rather than having people grind through data and invest in automating rote work, staff can focus on work

that requires their unique expertise and knowledge. In addition to producing savings by requiring fewer FTEs, these niche technologies can also accelerate the pace of change as staff focuses on driving improvements.

Unfortunately, operational leaders often don't get exposure to these new technologies. The CIO should both scan the market for technologies that will streamline and improve major processes, as well as promote thoughtful consideration of proposals that operational leaders bring forward.

Leveraging the right technology for cost improvement

As CIOs look toward the future and how they can make a positive impact, their No. 1 focus should be expediting the flow of meaningful information into the hands of those who need to make decisions — in all areas of the health system. We know for sure that the technology is there to take healthcare to the next level: to make it more efficient, more predictable, more personalized and more automated. It is the responsibility of the CIO to lead the organization forward in this post-EHR era to a brighter future where healthcare is not only more effective, but also more sustainable for many years to come. ■

HOW CAN HOSPITALS IMPROVE PERFORMANCE AND REDUCE SUBSIDIES FOR ANESTHESIA SERVICES?

Changes in the industry continue to impact revenue and costs associated with providing anesthesia services, and the subsidy required to maintain a productive level of service can be a major expense.

Digging deeper into the factors behind the subsidy may reveal opportunities to reduce the cost while still achieving excellent performance. A good anesthesia group will be able to provide expertise and leadership to optimize the practice.

This new white paper focuses on the specific challenges hospitals and anesthesia providers face in providing high quality, cost effective care, with recommendations on how to to improve across clinical, operational and financial metrics.

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Is Interoperability Getting Better or Worse? 6 Key Thoughts

By Akanksha Jayanthi and Max Green

The interoperability discussion is perpetual and all-inclusive. Providers want it, the federal government mandates it and vendors get caught in debate about it.

Definitions of interoperability vary, and the term is often used interchangeably — and incorrectly — with data exchange. What interoperability is not — and what data exchange is — is the sending and receiving of information from other systems or platforms. Email does that. Interoperability is the ability of disparate IT systems to send and receive data seamlessly, interpret that data and display the information in a readable, usable format, and add to the longitudinal patient record.

Collectively, the healthcare industry laments the state of interoperability, saying the capabilities for this type of interaction aren't where they needs to be, or blaming certain parties for inhibiting advancement in this arena. Borrowing from two health IT leaders' thoughts is the idea that the industry owes it to their patients to progress, and quickly.

"As healthcare professionals, and as an industry, we can no longer accept the status quo. It is possible to have real-time, two-way, low-cost, standards-based connectivity that enables improved decision-making and assures safety at lower cost," wrote Michael M. E. Johns, MD, founding chairman of the Center for Medical Interoperability, and William Stead, MD, chairman of the technical advisory committee of the Center for Medical Interoperability, in a contributed piece to *Becker's Hospital Review*.

That said, what is the current state of interoperability? Here are six thoughts.

1. In many regards, interoperability seems stagnant, and not for lack of technology. It's trite, but healthcare is the slowest industry in the uptake of meaningful and useful data exchange. The financial industry is lauded as a prime example of interoperability, as no matter which bank one uses, that individual can go to any ATM to withdraw money, thanks to ATM networks like NYCE, Cirrus and Star. Doug Dietzman, executive director of Great Lakes Health Connect in Michigan, a health information exchange, outlined this example in a previous interview with *Becker's Hospital Review.*

2. However, that doesn't mean vendors aren't exchanging information or utilizing networks to share information. Epic's self-reported data indicates the vendor exchanged 15.3 million patient records on the company's Care Everywhere network in June 2015 between Epic EHRs, with non-Epic EHRs, HIEs and government agencies. Other vendors including Cerner, Allscripts, McKesson and athenahealth are developing coalitions and collaborations to develop solutions fostering interoperability, notably the CommonWell Health Alliance. Throughout the industry data is being exchanged and presumably used. But there remain opportunities for advancement and more efficient, effective ways of interoperating.

3. There's a kind of chicken-and-egg question in the interoperability universe regarding where that advancement will come from. Which needs to and which will come first: The regulations and policies that require interoperability, or the technology that demonstrates that is it achievable? One important factor sometimes overlooked is the lack of a sustainable business model for health information exchange that is centered around patients, Charles Jaffe, MD, CEO of Health Level Seven International, told *Becker's Hospital Review* in a previous interview. Hot topics like information blocking and pointing fingers at which big-name vendors do and don't contribute to advancing interoperability tend to overshadow this overarching and more difficult issue.

4. That's not to say positive byproducts of the increasing discussion around healthcare interoperability aren't widespread. Evaluations like the KLAS Interoperability Report, which could impact public perception of EHR vendors, has placed more pressure on them to stretch their interoperability capabilities as far as they can. While the ONC has worked to release a final interoperability roadmap, many states and regions have taken data exchange matters into their own hands, incentivizing providers to link up, adopt standards and share information by offering them a broader view of patient care across the continuum. On one hand, it could be said that efforts like these don't amount to true interoperability — exchanging patient data and being able to meaningfully use and access it. On the other, they are slowly laying the infrastructural and regulatory groundwork that will be necessary when fully realized interoperability comes along.

5. The change is slow coming, and incentives aren't bountiful, leading to understandable frustration with the industry's progress in interoperability. "From my perspective, the improvements in this are at best marginal. As I talk with healthcare organizations trying to connect their systems with each others, it still seems like a tremendous amount of work and custom fees and consulting to really make things work between vendors, products and services," says Scott Becker, JD, publisher of *Becker's Hospital Review.*

6. It's fair to say interoperability isn't getting worse. But the drawn out process to move interoperability forward — and the associated pain points with doing so — eclipse the positive ground that is gained in incremental steps. It's a slow process, but the persisting discourse helps move healthcare closer to where it should be. ■

Mayo Clinic Sells Data Center to Epic for $46M

By Akanksha Jayanthi

Rochester, Minn.-based Mayo Clinic and Epic Systems have entered a $46 million sale-leaseback deal for the health system's 62,000 square-foot data center, reports *Minneapolis/St. Paul Business Journal*.

In a sale-leaseback deal, the asset owner sells the asset and then leases it from the new owner. In this case, Mayo is selling the data center to Epic and then plans to lease it for at least four years. Mayo has the option to continue the deal forever, according to the report.

An Epic spokesperson says the deal benefits both organizations. "Epic needed a high quality disaster recovery data center that was some distance away from its production data center yet still close enough to get to easily. Mayo had a high quality data center in an excellent location that was too large for their needs. The terms for the purchase and the terms for Mayo's portion that they will lease from Epic are at industry standard prices."

In January 2015, Mayo announced plans to adopt Epic's EHR and revenue cycle platforms. As part of this transition, Epic is also building a $6.1 million electronic substation that will support the enhanced needs of the data center. In October, it was reported Epic was working with Rochester Public Utilities to construct the new substation. The vendor will pay for the majority of the project, and RPU will contribute slightly more than $1 million for additional features.

"Due to the planned transfer of selected Mayo Data Center assets to Epic, Epic requests incremental electrical capability and capacity, needed to accommodate projected business growth in forward years," according to a memorandum regarding the substation project. ■

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How Billing and Collections Impact the Patient, and What Providers Can Do to Protect Their Bottom Line

Billing and payment for medical procedures are often overlooked aspects of the patient experience and may be the reason many physicians are seeing increases in patient complaints and their bad debt year over year.

Confusing medical bills and frustrating collections processes can derail satisfactory clinical experiences in the hospital or at a physician's practice. Disgruntled patients unsettled by complex bills – then collection letters and poor interactive voice technology phone calls – are less likely to understand their financial responsibilities, and subsequently, less likely to pay on time or at all.

This is an increasingly prevalent problem, especially as insurance carriers see more consumers enrolling high-deductible health plans, in which they are responsible for a significantly greater share of their healthcare costs. Since the advent of the health savings account in 2003, deductibles have increased as employers resist escalating premiums. According to the Kaiser Family Foundation, the percentage of covered workers with deductibles of $1,000 or more rose from 10 percent in 2006 to 46 percent in 2015 – a 360 percent jump. Among covered workers with a general annual deductible, the average deductible for single coverage in 2015 was $1,318, up from $917 in 2010.

"The [greatest] impact today is the big shift from business-to-business healthcare to business-to-consumer healthcare," says T. Scott Law, founder and CEO of Zotec Partners, a revenue cycle and practice management provider based in Carmel, Ind. He says the increasing prevalence of HDHPs has had "a material impact on the revenue cycle process," as these plans characterize a major shift in the responsibility to pay.

Prior to this shift to high deductible health plans, the carrier would cover about 80 percent of medical expenses, according to Mr. Law. Now, with patients accountable for almost all of the first $1,200, bad debt is rising, according to public accounting and consulting firm Crowe Horwath's first quarter 2015 edition of its hospital benchmarking data.

The Crowe RCA Benchmarking Analysis, which evaluated 420 hospitals, showed as the number of HDHP enrollees increased from 15.5 million in 2013 to 17.4 million in 2014, insured patients' share of total uncompensated care increased dramatically, with bad debt up 22 percent and charity care rates up 130 percent in Medicaid expansion states. In non-expansion states, bad debt and charity care rates rose 35 percent and 130 percent, respectively.

These trends underscore the need for hospitals and physician practices to implement solutions that can enhance the patient/consumer collections process and safeguard the revenue cycle by making the experience easier for patients.

To Create an Effective Billing and Collections System, Focus on Customer Service

In essentially all industries outside of healthcare, companies ceaselessly strive to provide the best possible customer service. Healthcare lags substantially in that sense because previously, third-party payers paid the bills. From long wait times to spotty transparency into cost and quality information to incomprehensible medical bills, healthcare consumers commonly endure less than desirable experiences navigating the healthcare system. At the same time, they have grown accustomed to exceptional customer service in other industries and expect the same consumer-centric treatment in their healthcare.

Mr. Law gave the example of Amazon, one of the most highly esteemed companies in terms of customer service. "On Amazon, you get prime service," he says. "Your package is delivered right to your house – fast. Consumers are expecting that kind of interaction with healthcare billing. If that provider can't give that experience, it reflects negatively on the overall experience."

When an Amazon customer reports a problem, a customer service professional responds in a rapid manner, illustrating an emphasis on fulfilling consumers' demands for immediate help and highlighting Amazon's commitment to customer service. Unfortunately, that kind of timeliness is not common in healthcare. When it comes to medical bills, which patients will likely have questions about, the lack of timely response can damage the patient's overall experience.

Negative patient experiences can translate to reduced patient satisfaction scores in HCAHPS surveys, which ultimately impact reimbursement. Bad experiences can also lead to patients not understanding or even avoiding paying their bills.

Build a Foundation for Billing and Collections Grounded in Best Practices

To prevent the billing process from tarnishing patients' experiences, healthcare providers must focus on two principal strategies: managing patients' expectations upfront and empowering them to be more accountable for fulfilling their financial responsibilities, according to Mr. Law.

Central to managing patients' expectations is presenting the hospital or physician practice's billing department as professional, friendly and dedicated to providing the most worry-free collections process.

Mr. Law says it is concerning "when physicians must oversee billing and collections duties on top of caring for their patients." These added responsibilities can have a negative impact on the overall quality of care, may contribute to a diminished view of the practice overall and result in poor interactions between patients and staff.

"I think [practices and hospitals] should be investing in training their people," says Mr. Law. "There should be staff who are there solely for collecting money and insurance information," as opposed to clinicians juggling these responsibilities on top of their clinical ones.

However, in reality, many physician practices and hospitals

do not have the bandwidth to designate or hire employees to work exclusively on billing and collections. In these cases, providers might outsource these responsibilities to revenue cycle solutions companies that can implement effective billing and follow-up methods to ensure patients pay their bills.

Zotec Partners' solutions enhance revenue cycle interactions to help instill positive patient perceptions of the healthcare experience, and secure reimbursement and future service revenues for providers. The company employs a patient experience methodology that empowers patients to make payments through several tools that are easy and convenient to use.

Its advanced interactive voice response technology includes a simple authentication process, an understandable format with minimal menu options so it is easy for patients to navigate, convenient text-back features, quick payment options and immediate live operator assistance. Zotec Partners operates a call center led by a customer service expert trained in optimizing the patient experience. It also offers a secure and user-friendly patient portal that can be used on a desktop computer or mobile device. Using the portal, patients can pay their bills, view their account history, request statements and update insurance information.

As in other industries, the key to securing a positive experience and safeguarding payments from consumers is simplicity and ease of use. With solutions like Zotec Partners', patients have access to several convenient and straightforward tools to pay their bills. However, it is important to vet revenue cycle companies carefully as they are not all created equal – many still use outdated follow-up collections methods that emerged years ago.

With companies that specialize in billing and collections and help safeguard positive patient experiences, there is no need to overburden the clinical staff to manage these responsibilities, which can be challenging for those not trained to handle them.

"A doctor is a seasoned professional in caring for their patients and diagnosing the issue based on their training and education, not just on what patients say," says Mr. Law. "Apply that same science to billing."

For a Positive Experience, Arm Patients with Information

Hospitals and physician practices must adopt a "help me help you" mentality when it comes to billing and collections. Whether they seek an external partner that specializes in securing patient payments or acquire the resources to enhance their own billing and collections department, interactions with patients should always be consumer-centric.

In addition to providing the portals and tools for actually making payments, the key is to provide patients with all of the information necessary to understand what they owe and when payments are due.

"The first thing you have to do is introduce the process to the patient at the time of service," says Mr. Law. Clearly explaining the series of steps involved in the billing and collections process to patients upfront remedies any worries they might have regarding the payment process. It also helps patients feel more in control of their healthcare experience because they will know what to expect when they receive their bills.

To achieve this, many providers send a letter of introduction to patients that details the billing and collections process ahead of the time of service, followed by subsequent letters requesting payment.

However, written letters can cause issues of their own.

"It is frustrating to send a patient letters four or five times," says Mr. Law regarding instances in which letters are sent but the patient does not make a payment. "You have to be able to resolve these issues quickly and efficiently."

That is why broader follow-up methods, such as claim-tracking status, patient portals, interactive voice response technology and text messaging, are more effective. "Those are all consumer-driven events that many providers are ill-equipped to handle" without procuring outside support. While not representative of the majority of the patient population, some patients are inclined to avoid paying their bills, and the increasing rate of HDHPs could exacerbate this problem. Therefore, it is imperative to be as vigilant in collections and follow-up efforts as possible.

These "consumer-driven" modes of communication also help expedite possible discounts that can be awarded to patients, in turn helping speed up receipt of payment.

Conclusion

Patients expect and demand the same level of customer service they are used to receiving in the retail, dining and travel industries. Billing and collections – though not a clinical aspect of healthcare – is a critical factor in determining patient satisfaction. With the proper systems and tools, hospitals and physician practices can empower their patients to take greater accountability for their financial responsibility, and providers will see an increase in revenues.

As the population of patients with HDHPs grows, the need to enhance the billing and collections process has become particularly pertinent. The evidence is plain; data shows a positive correlation between the increasing rate of HDHPs and uncompensated care, as well as patient complaints or requests for discounts. Hospitals and physician practices can implement best practices to mitigate these trends in their billing and collections department, such as managing patients' expectations upfront and empowering them to be more accountable to pay their bills. Alternatively, healthcare providers can seek help from dedicated professionals trained to do just that. Whichever direction providers choose, it is essential to understand carriers will no longer completely pay for services rendered. Healthcare providers cannot just ignore the largest payer – the patient – or they will see the effect in their bottom line. ■

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Founded in 1998 by CEO T. Scott Law, Zotec Partners is the Indianapolis-based industry leader in specialized medical billing and practice management services for the hospital-based specialty market. Zotec Partners is committed to the continual pursuit of excellence in the physician revenue cycle management industry by delivering effective solutions through its proprietary technology, personalized service and measurable client results. Currently, the company serves more than 8,000 physicians in all 50 states.

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100 Hospital & Health System CIOs to Know 2016

Becker's Hospital Review is pleased to release the 2016 edition of its list of 100 Hospital and Health System CIOs to Know. The executives are leading their organizations through healthcare's technology revolution, overseeing EHR installations, new patient portals and telemedicine advancements while working to keep data secure from breaches, among countless other priorities.

The *Becker's Hospital Review* editorial team selected leaders for this list based on editorial research and discretion, including prominent CIOs and those who head up IT for some of the nation's largest and most respected hospitals and health systems. *Note: This list is not an endorsement of included hospitals, health systems or associated providers. Leaders could not pay for inclusion on this list. Leaders are presented in alphabetical order.*

Michael Archuleta. Director of IT for Mt. San Rafael Hospital (Trinidad, Colo.). Mr. Archuleta joined Mt. San Rafael Hospital in 2012 as director of IT, inheriting a hospital with no health IT team, data center or crucial cybersecurity plan. Now, with Mr. Archuleta's leadership, the hospital achieved stage 2 of meaningful use and was named one of the "Most Wired" hospitals by *Hospitals & Health Networks* in 2015. In addition to his role at Mt. San Rafael Hospital, Mr. Archuleta sits on the CHIME Planning Committee.

Pamela Arora. Senior Vice President and CIO of Children's Health System of Texas (Dallas). Under Ms. Arora's leadership, Children's Health System of Texas achieved Stage 7 of HIMSS EMR Adoption Model in 2010. Her previous positions include serving on the board of the Dallas Children's Advocacy Center for four years and as CIO of Worcester, Mass.-based UMass Memorial Health Care.

Pamela Banchy, RN. CIO of Western Reserve Hospital (Cuyahoga Falls, Ohio). Ms. Banchy has more than 15 years of health IT experience and has been in healthcare for more than 30 years. Before becoming CIO of Western Reserve, she was the system director of clinical information systems for Summa Health System. Ms. Banchy is certified in nursing informatics and is a certified project management professional.

Daniel Barchi. CIO of NewYork-Presbyterian (New York). Mr. Barchi took on the CIO role at NewYork-Presbyterian in December 2015. He was previously senior vice president and CIO of Yale New Haven Health System and Yale School of Medicine in New Haven, Conn. There, he led the implementation of an EMR across three hospitals, among other accomplishments. Mr. Barchi has also previously served as CIO of Roanoke, Va.-based Carilion Health System.

Mark Barner. Senior Vice President and CIO of Ascension; CEO of Ascension Information Services (St. Louis). In the dual roles of CIO of Ascension and CEO of AIS, Mr. Barner manages IT operations, strategy, project execution and service delivery. Before becoming CIO of Ascension Health in 2008, he was CIO of Seton Healthcare Family in Austin, Texas, and regional CIO for Ascension Information Services. Mr. Barner is an active member of CHIME and HIMSS and also participates in Bipartisan Policy Center initiatives.

Gary Barnes. Senior Vice President and CIO for Medical Center Health System (Odessa, Texas). Mr. Barnes has been with Medical Center Health System for nearly 30 years and was previously with IBM. Mr. Barnes is active with CHIME, serving on the board of directors from 2009 through 2012 and on several committees. He has also been a member of HIMSS since 1988 and is a certified professional in healthcare information and management systems.

Jayne Bassler, RN. CIO of Florida Hospital (Orlando). Ms. Bassler has served as CIO of Florida Hospital in Orlando since 2012. In 2015, she took on additional responsibility as senior executive officer for population health services for the Florida division of Adventist Health System. Outside of these roles, Ms. Bassler is a member of the Healthcare Informatics Advisory Council for the O'Neil Center.

Christ Belmont. Vice President and CIO of University of Texas MD Anderson Cancer Center (Houston). Mr. Belmont has been vice president and CIO of University of Texas MD Anderson Cancer Center since 2013. He is leading MD Anderson through a systemwide Epic EHR implementation. Previously, he served as the system vice president and CIO of Ochsner Health System in New Orleans. He has more than 30 years of experience in health IT, holding various leadership positions at companies including IBM, Siemens and Healthlink.

Julie Berry. CIO of Steward Health Care System (Boston). Ms. Berry has more than 20 years of experience in healthcare technology. Before becoming Steward's CIO, she was vice president and chief technology officer of the for-profit system. She also gained experience on the IT executive team of Boston-based Partners HealthCare and Blue Cross Blue Shield of Massachusetts. Ms. Berry serves on the boards of several organizations, including the Massachusetts Health Data Consortium technical advisory board.

John Bosco. Senior Vice President and CIO of Northwell Health (Great Neck, N.Y.). Mr. Bosco heads up IT functions at Northwell Health, formerly North Shore-Long Island Jewish Health System. He joined the system in 2004 as vice president and chief technology officer and has more than 25 years of experience in IT management. Before joining Northwell, Mr. Bosco was associate vice president of information technology for Continuum Health Partners in New York.

Robert Brandner. CIO of Spectrum Health Systems (Worcester, Mass.). Mr. Brandner has years of experience at Dell Computers in IT enterprise architecture. He joined Spectrum Health Systems as CIO in November 2015 as its first CIO. Additionally, he serves as the organization's HIPAA security officer. At Spectrum, Mr. Brandner is responsible for providing leadership and vision for the health system's IT programs.

Geoffrey Brown. CIO of Piedmont Healthcare (Atlanta). Mr. Brown was appointed CIO of Piedmont Healthcare in 2014. Under his leadership, all six of the system's hospitals received *Hospitals & Health Networks*' "Most Wired" designation. Additionally, Mr. Brown led his team in the health system's first undercover phishing experiment in 2015, which helped establish employee education standards for information security compliance. Prior to joining Piedmont, Mr. Brown was senior vice president and CIO at Inova Health System, based in Falls Church, Va.

Paul Browne. Senior Vice President of Applied Informatics and CIO of Tenet Healthcare (Dallas). Tenet appointed Mr. Browne senior vice president and CIO in 2012. In addition to his leadership roles at Tenet, he sits on the clinical advisory council for the Leidos Partnership for Defense, which will advise Leidos on the Defense Healthcare Management System Modernization contract. Mr. Browne has previous experience serving as CIO and senior vice president for strategic program management at Trinity Health in Livonia, Mich.

Jon Burns. Senior Vice President and CIO of University of Maryland Medical System (Baltimore). Mr. Burns has more than 30 years of experience in nonprofit healthcare. He joined The University of Maryland Medical System in 2006. Previously, he was senior executive of information technology services at Cleveland Clinic. Mr. Burns also led technology services at the Cleveland Clinic Lerner College of Medicine.

Bobbie Byrne, MD. Vice President and CIO of Edward-Elmhurst (Ill.) Healthcare. Dr. Byrne was named CIO of Edward-Elmhurst Healthcare in 2013, shortly after the organization was formed by the merger of Edward Hospital and Health Services in Naperville, Ill., and Elmhurst Memorial Hospital. She is responsible for all IT, applications and biomedical engineering for the health system. Dr. Byrne completed her medical degree at Northwestern University in Evanston, Ill., and a pediatrics residency at Children's Memorial Medical Center in Chicago.

Deborah Cancilla. CIO of PinnacleHealth System (Harrisburg, Pa.). Ms. Cancilla, CIO of PinnacleHealth since 2014, is leading an enterprisewide Epic EHR installation, which will span three hospitals and more than 74 ambulatory and specialty sites. She is also in the process of consolidating a fragmented staff to a centralized location with an open concept floor plan. Ms. Cancilla's previous experience includes six years as senior vice president and CIO of Grady Health System in Atlanta.

Mike Canfield. CIO of Augusta Health System (Fishersville, Va.). Mr. Canfield stepped into his role at Augusta Health System in January. Previously, he was vice president and CIO of Firelands Regional Medical Center in Sandusky, Ohio. During his time at Firelands Regional, he led a number of initiatives such as bedside medication verification, EHR replacement and computerized physician order entry. Mr. Canfield also actively participated in his local HIMSS chapter and Ohio's health information exchange.

Kumar Chatani. Executive Vice President and CIO of Mount Sinai Health System (New York). Mr. Chatani served as vice president and regional CIO of Kaiser Permanente, Northwest Region in Portland, Ore., for nearly nine years before joining Mount Sinai as executive vice president and CIO in 2011. At Mount Sinai, he is responsible for a team of 800 employees and a budget of approximately $240 million. Under his leadership, the health system received the HIMSS Enterprise Davies Award in 2012.

Matthew Chambers. CIO of Baylor Scott & White Health (Dallas). Mr. Chambers served as CIO of Scott & White Healthcare until 2013, when it merged with Baylor Health Care System. Soon after, he became CIO of the newly formed system, where he has helped created a connected network of providers through a health

information exchange. He is also a certified healthcare CIO from CHIME. Before he began working in healthcare, Mr. Chambers served in IT leadership positions at KPMG and BearingPoint.

Marc Chasin, MD. System Vice President and CIO/CMIO of St. Luke's Health System (Boise, Idaho). Though Dr. Chasin began working at St. Luke's in 2010, he was appointed to interim CIO/CMIO in November 2012. One month later, he was officially named CIO and CMIO for the system. Dr. Chasin has been instrumental in the implementation of an Epic EHR system at St. Luke's. He has served on various boards, including the Idaho Health Data Exchange and Care Everywhere Network at Epic Systems.

Carl Christensen. Vice President and CIO of Northwestern Memorial HealthCare (Chicago). In addition to serving as CIO of NMHC, Mr. Christensen is also CIO of Northwestern University's Feinberg School of Medicine. In his current role, Mr. Christensen is responsible for IT operations and developing and implementing IT strategy for Northwestern Medicine. Mr. Christensen has been with Northwestern since 2010, previously serving as vice president and CIO of Northwestern Medical Faculty Foundation. He has a master's degree from Syracuse (N.Y.) University.

George Conklin. Senior Vice President and CIO of CHRISTUS Health (Irving, Texas). Mr. Conklin has been with CHRISTUS Health since its inception in 1999. Before joining CHRISTUS, one of the largest nonprofit health systems in the nation, he was with Integris Health in Oklahoma City. In addition to overseeing all aspects of information management and communications for CHRISTUS, Mr. Conklin also oversees all of the system's clinical engineering services. He also writes and speaks on various topics.

Andy Crowder. CIO and Corporate Senior Vice President of Scripps Health (San Diego). The recently appointed Mr. Crowder took the role of CIO and corporate vice president of Scripps Health Jan. 18. With almost 30 years of IT experience, Mr. Crowder replaced Patric Thomas, who will retire Feb. 20. Previously, Mr. Crowder worked as senior vice president and CIO of Portland-based MaineHealth, where he led the system's successful Epic implementation. He also worked as CIO for Orlando-based Florida Hospital and Altamonte Springs, Fla.-based Adventist Health System.

Richard (Dick) Daniels. Executive Vice President and CIO of Kaiser Permanente (Oakland, Calif.). Mr. Daniels began his role as executive vice president and CIO of Kaiser in February 2015. He brings more than 30 years of shared services and IT leadership experience to the position. He joined Kaiser in May 2008 as IT senior vice president and business officer of health plan and hospital operations. He has also served as Kaiser's senior vice president of Enterprise Shared Services. Prior to joining Kaiser, Mr. Daniels held various leadership positions at Capital One and JP Morgan Chase.

Randy Davis. Vice President and CIO of CGH Medical Center (Sterling, Ill.). In his current position, Mr. Davis serves as vice president of support services and CIO of CGH Medical Center. Before becoming a CIO, he spent 30 years as an administrator for physician multispecialty group practices. Mr. Davis served as an administrator of Sterling (Ill.) Rock Falls Clinic before it became integrated with CGH Medical Center in 2011.

Myra Davis. Senior Vice President of Information Services and CIO of Texas Children's Hospital (Houston). In December 2012, Ms. Davis began serving as senior vice president of information services and CIO of Texas Children's Hospital. In her position, she assists the operation and services of the IS department. Prior to her current position, Ms. Davis was the hospital's vice president of information systems. She is a CHIME board member and holds a master's degree in software engineering from St. Paul, Minn.-based University of Saint Thomas.

Frank DiSanzo. Executive Vice President, Chief Strategy Officer and CIO of Saint Peter's Healthcare System (New Brunswick, N.J.). In 2008, Mr. DiSanzo began his role as chief strategy officer and CIO of Saint Peter's. Under his leadership, Saint Peter's has been named a "Most Wired" hospital by *Hospitals & Health Networks* annually since 2013. Previously, Mr. DiSanzo was CIO of Staten Island (N.Y.) University Hospital. He holds an MBA from West Long Branch, N.J.-based Monmouth University and serves on the board of multiple organizations, including the Ronald McDonald House.

Jake Dorst. CIO of Tahoe Forest Health District (Truckee, Calif.). Mr. Dorst began his role as CIO of Tahoe Forest Health District, which includes Tahoe Forest Hospital, in August 2014. In May 2015, he also began serving as the district's interim CEO, a position he held until December 2015. Previously, Mr. Dorst served as vice president and CIO of Hagerstown, Md.-based Meritus Health and CIO of Petersburg, Va.-based Southside Regional Medical Center. He has also held IT leadership positions at Franklin, Tenn.-based Community Health Systems and Madison, Ind.-based The King's Daughters' Hospital.

Marcy Dunn. Senior Vice President and CIO of Catholic Health Services of Long Island (Rockville Centre, N.Y.). Ms. Dunn first joined Catholic Health Services in 2001, after working with the system as a consultant. Since officially joining the six-hospital system, Ms. Dunn has spearheaded the CHS eHealth program, which includes implementation of the Epic EHR, creation of a high-performing network and the launch of a patient portal. Prior to her work with CHS, Ms. Dunn served as CIO of Episcopal Health Services in Far Rockaway, N.Y. Ms. Dunn is a member of HIMSS and CHIME.

Adrienne Edens. Valley Area CIO of Sutter Health (Sacramento, Calif.). With more than 30 years of health IT experience, Ms. Edens was named CIO of the Valley Area in August 2015. She first

came to Sutter in 2012 as regional CIO for the East Bay Region. Prior to joining Sutter, Ms. Edens was system vice president and CIO of St. Luke's Health System in Boise, Idaho, and member of the board of the Idaho Health Data Exchange and the Idaho Health Information Exchange. She earned a master's degree in applied psychology from the University of Santa Monica (Calif.). Ms. Edens is a fellow and past board member of CHIME, a faculty member for the CHIME CIO boot camp and a board member of HIMSS.

Dee Emon, BSN. Vice President and CIO of Wake Forest Baptist Medical Center (Winston-Salem, N.C.). Ms. Emon stepped into her current role with Wake Forest Baptist Medical Center last April. Previously, Ms. Emon served as the medical center's chief clinical information officer. Before trying her hand at IT, Ms. Emon had an accomplished career in operations, with experience as a chief quality officer, chief nurse executive and interim CEO. A Malcom Baldridge examiner and a Six Sigma Black Belt, Ms. Emon also holds a master's degree in management from Cardinal Stritch University in Milwaukee.

Dick Escue. CIO of Valley View Hospital (Glenwood Springs, Colo.). Mr. Escue took the helm of IT at Valley View Hospital in September 2013. With more than 25 years of experience, he has been a staunch advocate for interoperability. Prior to joining Valley View Hospital, Mr. Escue served as vice president and CIO of Memphis, Tenn.-based Baptist Memorial Health Care, Chesterfield, Mo.-based Sisters of Mercy Health System and RehabCare Group in Louisville, Ky. He holds an MBA from the University of Memphis in Tennessee.

Ferdinand Feola. Vice President and CIO of Pocono Medical Center (East Stroudsburg, Pa.). Mr. Feola has been with Pocono Medical Center since 2008 and CIO since October 2013. Prior to his current role, he oversaw operations of the hospital's strategic health IT projects as strategic project manager. He has more than 25 years of leadership experience in IT across multiple verticals, including banking, retail and radio. Mr. Feola holds a master's degree in Christian leadership from the University of Valley Forge in Phoenixville, Pa.

Rick Frederick. CIO of Cottage Hospital (Woodsville, N.H.). Mr. Frederick stepped into his role as CIO in 2014 after serving for three years as director of Cottage Hospital's information technology department. Under Mr. Frederick's direction, the critical access hospital became one of just eight hospitals nationwide and the only in New Hampshire to successfully attest to meaningful use stage two in the first qualifying period. Mr. Frederick a master's in health management and policy from the University of Massachusetts Lowell.

Shirley Gabriel. Vice President of Information Systems and CIO of University Health Care System (Augusta, Ga.). Ms. Gabriel came to University Health Care System in early 2015 after serving as vice president and CIO of the University of Arizona Health Network in Tucson. During her tenure with UA Health Network, Ms. Gabriel helped implement a $100 million common Epic EHR. Prior to UA Health System, Ms. Gabriel worked in various IT capacities at Summa Health System in Akron, Ohio. She is expected to complete her master's in health administration this year from Ohio University in Athens.

Roland Garcia. Senior Vice President and CIO of Baptist Health (Jacksonville, Fla.). Mr. Garcia has been senior vice president and CIO of Baptist Health since 2001. During his tenure, Mr. Garcia led EHR implementation and conversion to all-digital facilities systemwide, among other accomplishments. Prior to joining Baptist Health, Mr. Garcia spent 15 years with Baptist Health Care in Pensacola, Fla., where he served as vice president and CIO. Mr. Garcia is involved locally as a member of the Leadership Jacksonville Class of 2006, Jacksonville CIO Council, Jacksonville Regional Chamber of Commerce CIO Council and the Northeast Florida HIE CIO Council.

Indranil (Neal) Ganguly. Vice President and CIO of JFK Health System (Edison, N.J.). Mr. Ganguly joined JFK Health System in November 2013 as vice president and CIO with nearly 15 years of CIO experience under his belt. He previously served as CIO of CentraState Healthcare System in Freehold, N.J. Mr. Ganguly has served on the board of directors for CHIME and in various leadership roles with HIMSS, including chair of the public policy committee, board member and president. Mr. Ganguly holds an MBA from New York Institute of Technology-Old Westbury.

Sreekant Gottimukkala. CIO of Prime Healthcare Services (Ontario, Calif.). Mr. Gottimukkala became CIO of Prime Healthcare in 2006, and then vice president and CIO of Prime in 2012. In his current position, Mr. Gottimukkala oversees the technology in 38 acute care hospitals in 11 states. Previously, he was an architect with IBM Global Services and American Express and a project leader with Intelligroup and Indus Business Systems. He completed a master's degree in computers at Nagarjuna University in Guntur, India.

Joy Grosser. Vice President and CIO of UnityPoint Health (West Des Moines, Iowa). Ms. Grosser has served as vice president and CIO of UnityPoint Health since 2009. Her previous roles includes CIO of the University of California Irvine Health Sciences System in Orange, as well as positions with the Loyola Health System in Maywood, Ill.; Health Midwest in Kansas City, Mo.; and Research Medical Center in Kansas City. Outside of work, Ms. Grosser serves as the Technology Association of Iowa chair and a Make-A-Wish Iowa board executive committee member.

C. Martin Harris, MD. CIO and Chairman of the Information Technology Division for Cleveland Clinic. Dr. Harris is a staff member in the Department of General Internal Medicine at the Cleveland Clinic, where he has also served as CIO and chairman

of the Information Technology Division since 2009. Throughout his career, Dr. Harris has served on many government and private sector commissions to address healthcare interoperability issues, including the Congressional Commission on Systemic Interoperability and the HIMSS National Health Information Infrastructure Task Force. Dr. Harris received his medical degree from the University of Pennsylvania School of Medicine in Philadelphia.

Steve Hess. CIO of University of Colorado Health (Aurora). Mr. Hess became CIO of University of Colorado Hospital in 2009. He served in that role until 2012, when the organization merged with Poudre Valley Hospital in Fort Collins, Colo.; Medical Center of the Rockies in Loveland, Colo.; and Memorial Health System in Colorado Springs, Colo., to form UCHealth. As CIO of UCHealth, Mr. Hess manages the information systems across the system's five Colorado hospitals and more than 100 clinic locations. Prior to joining UCHealth, Mr. Hess was the CIO of Wilmington, Del.-based Christiana Care Health System.

Kyle Johnson. Vice President and CIO of Eastern Maine Health Systems (Brewer). Ms. Johnson, a healthcare leader with more than 30 years of experience in healthcare, was appointed to her current role in 2014. She was previously the vice president and chief analytics and integration officer of Trinity Health in Livonia, Mich. Ms. Johnson earned a master's degree in medical informatics from Northwestern University in Evanston, Ill.

Liz Johnson, BSN, RN. CIO of Acute Care Hospitals & Applied Clinical Informatics for Tenet Healthcare (Dallas). As CIO of acute care hospitals and applied clinical informatics, Ms. Johnson oversees the health IT at 84 Tenet hospitals across the nation. In 2015, Tenet Healthcare recognized Ms. Johnson with a special leadership award to honor her team's successful completion of the original scope of the IMPACT program, Tenet's EHR initiative, on time and under budget. The award acknowledges just one of many significant contributions she has made during her 13-year tenure. Outside of Tenet, Ms. Johnson is a current member of the CHIME board of trustees.

Beverly Jordan, MSN, RN. Vice President and Chief Information and Transformation Officer of Baptist Memorial Health Care (Memphis, Tenn.). Baptist Memorial Health Care appointed Ms. Jordan to vice president and chief information and technology officer to lead the organization's transition to EHR vendor Epic in December 2015. Before the promotion, Ms. Jordan was the chief clinical transformation officer for roughly 3.5 years. She was the CNO of the system and of Baptist Memorial Hospital-Memphis for nearly a decade before that. This nursing veteran of nearly 30 years received her MSN from the University of Phoenix.

Mark Kilborn. CIO of Springhill Medical Center (Mobile, Ala.). For nearly 30 years, Mr. Kilborn served as the operations manager of Mobile (Ala.) Infirmary Medical Center. In 2000, Mr. Kilborn became area vice president of Allscripts Professional Services and CIO of Springhill Medical Center. Springhill made headlines in early 2015 when it became the first hospital in Alabama to achieve HIMSS Stage 7 Ambulatory Award, one of many advancements the facility has made in EHR implementation during Mr. Kilborn's tenure.

Suresh Krishnan. Vice President and CIO of Loretto Hospital (Chicago). Mr. Krishnan has been vice president and CIO of Loretto Hospital for nearly three years. Previously, he served as chief technology officer and information security officer for Northwest Community Healthcare in Arlington Heights, Ill., for more than a decade. Mr. Krishnan earned his bachelor's in mechanical engineering from Anna University — a technical university in India — in 1982. Today, his specialties include HIPAA security, enterprise architecture, EMR implementation and meaningful use.

Mary Anne Leach. Senior Vice President and CIO of Children's Hospital Colorado (Aurora). Ms. Leach became senior vice president and CIO in 2007. Since then, she has helped the hospital reap strategic, clinical, business and research value from technology enablers and investments. Under her leadership, *Hospitals & Health Networks* magazine named Children's Hospital Colorado a "Most Wired" hospital in 2015 for the third consecutive year. Prior to joining Children's, Ms. Leach was vice president of clinical applications for Englewood-based Catholic Health Initiatives.

Philip Loftus, PhD. Senior Vice President and CIO of SSM Health (St. Louis). Dr. Loftus joined SSM Health as senior vice president and CIO in January 2015, where he oversees the IT and clinical engineering services for the health system's acute care hospitals, physician practices and nursing homes. Prior, he was CIO of Milwaukee-based Aurora Health Care, where he led the system's Epic EHR implementation. Dr. Loftus earned his doctorate in computer-based modeling and simulation from the University of Liverpool in the United Kingdom.

Jonathan Manis. Senior Vice President and CIO of Sutter Health (Sacramento). As CIO of Sutter Health for nearly a decade, Mr. Manis oversees the health system's more than $1 billion investment in health technologies to improve patient care, including medication bar coding, the tele-ICU and the EHR. Mr. Manis joined Sutter in September 2006, prior to which he held leadership positions in two Illinois-based systems. Mr. Manis holds a master's degree in information science from the Naval Postgraduate School.

Ed McCallister. Senior Vice President and CIO of UPMC (Pittsburgh). Mr. McCallister assumed his current position in 2014. Previously, Mr. McCallister spent 15 years with UPMC's Insurance Services Division, first as director and then as vice president and CIO. He also held various business and IT man-

agement positions with the insurer Highmark in Pittsburgh for 12 years. As senior vice president and CIO of UPMC, Mr. McCallister leads more than 1,500 information services professionals.

William McConnell. Senior Vice President and CIO of Indiana University Health (Indianapolis). In addition to his senior vice president and CIO duties, Mr. McConnell also sits on the board of directors for cloud computing company Bluelock and the Indianapolis chapter of the American Heart Association. Mr. McConnell joined IU Health in 2012. Prior, he was president and CEO of FlowCo, an Indianapolis-based startup developing devices to help clinicians choose the proper sized stent to open arteries, and senior vice president of St. Paul, Minn.-based Boston Scientific Cardiac Rhythm Management.

Thomas McGill, MD. Vice President of Quality and Safety and CIO of Butler (Pa.) Health System. Dr. McGill joined Butler Health System's flagship Butler Memorial Hospital in 1993 as an infectious disease practitioner. He led Butler Health System to be one of the first two systems to join western Pennsylvania's first health information exchange ClinicalConnect in 2012. Dr. McGill earned his medical degree from University of Massachusetts and is board certified in internal medicine and infectious diseases.

Mark McMath. CIO of Methodist Le Bonheur Healthcare (Memphis, Tenn.). Though a newcomer to Methodist Le Bonheur Healthcare — he joined the system in August 2015 — Mr. McMath has a healthcare leadership career spanning more than 30 years, including 12 years as president and CIO of Indiana University Health Bloomington Hospital. Mr. McMath is a member of CHIME, HIMSS and the American College of Healthcare Executives. He has also volunteered in leadership positions for nonprofit organizations including Martha's House, an organization providing emergency temporary housing in Bloomington, Ind., and Carpet City Kiwanis Club.

Pamela McNutt. Senior Vice President and CIO of Methodist Health System (Dallas). Ms. McNutt has served as senior vice president and CIO of Methodist Health System since April 1993. In 2002, Ms. McNutt received the CHIME-HIMSS John Gall, Jr. CIO of the Year Award. She is also a fellow of both CHIME and HIMSS and has served on both organizations' boards of directors. Before joining Methodist, Ms. McNutt was administrative director of information systems and programming manager at Hermann Hospital in Houston.

Bruce Metz, PhD. Senior Vice President and CIO of Lahey Health (Burlington, Mass.). For more than 20 years, Dr. Metz has served in senior management and executive IT positions in healthcare and higher education. Dr. Metz has been with Lahey Health since April 2011, prior to which he was CIO at Philadelphia-based Thomas Jefferson University. He earned his PhD in applied psychology from New York University.

Aaron Miri. CIO of Walnut Hill Medical Center (Dallas). Walnut Hill Medical Center opened its doors in April 2014, and Mr. Miri came on board as CIO in February 2015. He previously was chief technology officer for Children's Medical Center in Dallas, director of IT services for Cook Children's Health Care System in Fort Worth, Texas, and manager of IT operations at Methodist Health System in Dallas. Mr. Miri is a HIMSS fellow and holds an MBA in healthcare services management from The University of Dallas.

Michael Mistretta. Vice President and CIO of Virginia Hospital Center (Arlington). Mr. Mistretta joined Virginia Hospital Center in 2015, bringing nearly 30 years of experience to the job of vice president and CIO. Previously, he was with Kaweah Delta Healthcare District in Visalia, Calif. Mr. Mistretta is a CHIME certified healthcare CIO and a certified professional in health information management by HIMSS. Mr. Mistretta attended the United States Military Academy in West Point, N.Y., and also earned an MBA from Ashland University in Ohio.

Dana Moore. Senior Vice President and CIO of Centura Health (Englewood, Colo.). Mr. Moore joined Centura Health in 2001 and has been responsible for the development and implementation of the system's IT strategy across its Colorado and Kansas facilities, comprising 15 hospitals. He has more than 20 years of experience in healthcare financial management. Prior to joining Centura Health was national director in charge of revenue cycle practice for Certus Corporation and president and founder of The Moore Consulting Group.

Jon Morris, MD. Senior Vice President and CIO of WellStar Health System (Alpharetta, Ga.). Prior to becoming CIO of WellStar Health System in 2011, Dr. Morris served as interim CIO and the system's first CMIO while practicing emergency medicine at Kennestone Regional Medical Center in Marietta and serving as a medical informatics consultant for WellStar. With his oversight, the system published a strategic IT roadmap in 2012 that has produced results such as achieving meaningful use stage two and being named one of *Hospitals & Health Networks*' 2015 "Most Wired" hospitals.

Pravene Nath, MD. CIO of Stanford (Calif.) Health Care. Dr. Nath first joined Stanford Health Care in 2008 as the system's CMIO before becoming CIO in 2013. Under his leadership, the system has earned national recognition for its IT achievements, including receiving the HIMSS Analytics Stage 7 award in 2013 and being named one of *Hospitals & Health Networks*' 2014 and 2015 "Most Wired" hospitals. Dr. Nath also teaches emergency medicine as a clinical assistant professor at the Stanford University School of Medicine.

Daniel Nigrin, MD. Senior Vice President for Information Services and CIO of Boston Children's Hospital. As CIO of Boston Children's, Dr. Nigrin — who is board certified in pediatric endocrinology and clinical informatics — oversees all of the hospital's clinical, research, teaching and administrative IT systems. Dr. Nigrin also serves as an assistant professor of pediatrics at Harvard Medical School, is a senior staff member of the Children's Hospital Informatics Program and is a practicing physician in Boston Children's division of pediatric endocrinology.

Jim Noga. Vice President and CIO of Partners HealthCare (Boston). Mr. Noga joined Massachusetts General Hospital as director of clinical applications in 1990 before assuming the role of CIO of the hospital in 1997. He was appointed vice president and CIO of the entire Partners system in 2011. He has a wide range of expertise, including a focus on online enterprise clinical reporting systems and closed loop medication administration. Additionally, Mr. Noga is a professor of health informatics at Northeastern University in Boston.

Joe Norris. CIO of New Hanover Regional Medical Center (Wilmington, N.C.). Prior to arriving at New Hanover Regional Medical Center, Mr. Norris was the associate vice chancellor and CIO of East Carolina University in Greenville, N.C. He has more than 25 years of experience in IT leadership and began his career at BB&T Corporation, where he led the systems and operations departments, and was also a senior analyst for Glaxo Wellcome pharmaceuticals. Mr. Norris was chief technology officer for NHRMC before being appointed CIO in 2014.

Laureen O'Brien. Vice President and CIO of Providence Health & Services (Renton, Wash.). With nearly 30 years of health IT experience, Ms. O'Brien joined Providence Health & Services in 1997 as director of information services in Oregon. Prior to joining the system, she was divisional director of information services at Columbia Healthcare Systems in Denver and spent time in the EHR vendor sector. Under her leadership, the system was named one of the 2015 "Most Wired" hospitals by *Hospitals & Health Networks*. Additionally, Ms. O'Brien is a member of the Health Information Technology Oversight Council for the state of Oregon.

Michael O'Rourke. Senior Vice President and CIO of Catholic Health Initiatives (Englewood, Colo.). Before being appointed CIO of Catholic Health Initiatives in 2009, Mr. O'Rourke was a private consultant with the health system for two years. With his oversight, the system consolidated more than 40 disparate IT operations into a single national infrastructure and reduced its overall operating IT budget by more than $30 in under three years. Mr. O'Rourke has more than 25 years of healthcare technology experience and previously held positions with Plano, Texas-based Triad Hospitals and San Francisco-based Dignity Health.

Jaime Parent. Vice President of IT Operations and Associate CIO of Rush University (Chicago). In addition to overseeing day-to-day technical operations and IT infrastructure for Rush University, Mr. Parent is also responsible for all of the school's IT research, support for its three graduate schools and school of medicine and is the graduate course director for health systems management. A retired lieutenant colonel in the Air Force, he founded the En-Abled Veteran program at Rush University in 2013, which provides IT training for military veterans and offers hands-on experience applicable for sought-after IT services and positions.

Marty Paslick. Senior Vice President and CIO of Hospital Corporation of America (Nashville, Tenn.). In his nearly 30-year career with HCA, Mr. Paslick served as vice president and COO of the system before being appointed to senior vice president and CIO in 2012. In his current position, he oversees the system's information technology and services department, which provides strategies for 165 hospitals and comprises more than 4,500 employees. Mr. Paslick is a member of the KLAS Advisory Board, past chairman of the board of the Nashville Technology Council and past board member of the Nashville Chamber of Commerce.

Doris Peek, PhD. Senior Vice President of IT and CIO of Broward Health (Ft. Lauderdale, Fla.). Since 2006, Dr. Peek has served as senior vice president of IT and CIO of Broward Health. During her tenure at Broward Health, the system's IT department has grown from 125 employees to 200. Among the other milestones during her tenure is a 95 percent adoption of computerized physician order processing entry and EHR. Dr. Peek holds a doctorate degree in organizational management.

Keith Perry. CIO of St. Jude Children's Research Hospital (Memphis, Tenn.). Mr. Perry is still fairly new to his position, as he was named CIO of St. Jude in 2015. Prior to St. Jude, he was associate vice president and deputy CIO of University of Texas MD Anderson Cancer Center in Houston. Mr. Perry earned an MBA from the University of Houston.

Cindy Peterson. Vice President and CIO of Henry Mayo Newhall Memorial Hospital (Valencia, Calif.). Ms. Peterson has more than 25 years of health IT experience. During her tenure at Henry Mayo Newhall, the hospital has implemented numerous applications from the organization's core clinical vendor, Meditech. Before joining Henry Mayo Newhall, Ms. Peterson was regional CIO of Roseville, Calif.-based Adventist Health, overseeing the IT departments of five hospitals in southern California.

Audrius Polikaitis, PhD. Assistant Vice President of Health Information Technology and CIO of University of Illinois Hospital Health Sciences System (Chicago). Dr. Polikaitis is responsible for all applications, systems and infrastructure that support the patient care, business and financial operations of UI Health. Under his tenure, the system achieved HIMSS Stage 6 designation. Before joining UI Health, Dr. Polikaitis worked in the corporate research labs of a Fortune 50 technology corporation, and for a major healthcare information

systems vendor. Dr. Polikaitis earned his PhD in electrical and computer engineering from the Illinois Institute of Technology.

Marc Probst. CIO of Intermountain Healthcare (Salt Lake City). Since 2003, Mr. Probst has served as CIO of Intermountain Healthcare. During his tenure, he has led the 22-hospital system through development and implementation of a system-wide EMR called iCentra in partnership with Cerner. In addition to his work as CIO, Ms. Probst is a member of the Federal Healthcare Information Technology Policy Committee, which assists in developing health IT policy for the U.S. government. He is the 2016 chair of the CHIME board of trustees.

Jayashree Raman. Vice President and CIO of Cooper University Health Care (Camden, N.J.). Ms. Raman has served as vice president and CIO of Cooper University Health Care since 2012. Before joining Cooper, she was vice president of healthcare strategy and CIO of Stanley Healthcare Solutions. She also was previously vice president and CIO of The Reading Hospital and Medical Center, now Reading (Pa.) Hospital, from 1997 to 2010, and director of technical operations at The Reading Hospital and Medical Center from 1987 to 1997.

David Rapp. Vice President of Supply Chain and CIO of Wheeling (W.Va.) Hospital. Mr. Rapp joined Wheeling Hospital in late 2006. During that time, he led a full EHR implementation, the computerization of the cardiology department and the replacement of the operating room system, among several other accomplishments. Mr. Rapp is an active member of HIMSS, serving on the organization's innovation committee, and is active in the local chapter of the Association of Information Technology professionals.

Stephanie Reel. CIO of Johns Hopkins University and Vice President for Information Services for Johns Hopkins Medicine (Baltimore). Ms. Reel has been vice president for information services at Johns Hopkins Medicine since 1994 and CIO and vice provost of information technology at Johns Hopkins University since 1999. During her time with Johns Hopkins, she has led the implementation of an electronic patient record and formed a governance structure that supports funding and priority-setting across the organization. Ms. Reel earned an MBA from Baltimore-based Loyola College in Maryland, now Loyola University Maryland.

George Reynolds, MD. Vice President, CMIO and CIO of Children's Hospital & Medical Center (Omaha, Neb.). Dr. Reynolds has been CMIO of Children's Hospital & Medical Center since 2004; he added the CIO role in 2010. During his tenure, the hospital received first place in Healthcare Informatics' Healthcare IT Innovators Awards, and the hospital has been recognized at least twice as one of *InformationWeek*'s top 250 innovators. Dr. Reynolds is board certified in general pediatrics and pediatric critical care. In addition to his medical degree, Dr. Reynolds holds a master's degree in medical management.

Craig Richardville. Senior Vice President and CIO of Carolinas HealthCare System (Charlotte, N.C.). Mr. Richardville joined Carolinas HealthCare System in 1997 and helped the system achieve HIMSS Stage 7 for both acute and ambulatory care facilities. Mr. Richardville received the 2015 CHIME-HIMSS John E. Gall, Jr. CIO of the Year Award. Mr. Richardville is a fellow with the American College of Healthcare Executives and HIMSS; board member of the University of North Carolina at Charlotte Foundation, CHS CareConnect and Carolinas Shared Services; and a member of CHIME, *Wall Street Journal* CIO Network and the Health Management Academy CIO Council. He holds an MBA.

Ed Ricks. Vice President of Information Services and CIO of Beaufort (S.C.) Memorial Hospital. Mr. Ricks has more than 20 years of healthcare information systems experience working with four health systems. Before joining Beaufort, Mr. Ricks was CIO of Samaritan Medical Center in Watertown, N.Y. He earned a master's degree in health administration from the University of North Carolina in Chapel Hill, is a member of HIMSS and CHIME and serves on several organizations' boards.

Bert Robles. Executive Vice President and CIO of Guthrie (Sayre, Pa.). Mr. Robles has more than 30 years of experience in management and information technology, both in business and healthcare settings. Before his appointment at Guthrie in 2015, Mr. Robles served as senior vice president and corporate CIO for NYC Health + Hospitals in New York. He also previously held the CIO position at State University of New York Downstate Medical Center in Brooklyn, N.Y.

Cris Ross. CIO of Mayo Clinic (Rochester, Minn.). Prior to joining Mayo Clinic in 2012, Mr. Ross served as executive vice president and general manager of the clinical interoperability business for Surescripts. He has more than 28 years of diverse experience in healthcare, information technology and government settings. Mr. Ross is actively involved with various industry innovation committees, including HHS' Health IT Standards Committee and the Markle Foundation Connecting for Health Steering Committee, and he previously served on the Patient Centered Primary Care Collaborative.

Robin Sarkar, PhD. CIO of Lakeland Health (St. Joseph, Mich.). Dr. Sarkar has held several leadership roles at Lakeland Health, including assistant vice president of information systems and director of information technology. Under Dr. Sarkar's leadership, Lakeland Health received HIMSS' Nicholas E. Davies Award of Excellence in 2014 as well as *Hospitals & Health Networks*' "Most Wired" recognition in 2015. Before joining Lakeland in 2013, Dr. Sarkar served as director of global information systems at Whirpool Corporation.

Sue Schade. Interim CIO of University Hospitals (Cincinnati). Ms. Schade has worked in the health IT industry for more than 30 years, serving in CIO positions for 15 of those years. She became

interim CIO of University Hospitals on Jan. 25 after serving as CIO of University of Michigan Health System in Ann Arbor from 2012 through 2015. At UMHS, she oversaw the deployment of the organization's new EHR system. Ms. Schade was named the 2014 John E. Gall, Jr. CIO of the Year by CHIME and HIMSS.

Rick Schooler. CIO of Orlando (Fla.) Health. Mr. Schooler joined Orlando Health in 2001 as vice president and CIO. He was previously CIO of Navicent Health, formerly Central Georgia Health System, in Macon. Mr. Schooler holds an MBA from the University of Indianapolis. Throughout his career, Mr. Schooler has earned several accolades, including Purdue University Distinguished Technology Alumni, CHIME-HIMSS John E. Gall, Jr. CIO of the Year Award and CHIME Innovator of the Year Award, among others.

Manish Shah. Senior Vice President and CIO of Community Health Systems (Franklin, Tenn.). Mr. Shah joined CHS in 2013 as deputy CIO and took over the CIO role at the for-profit health system in 2016, replacing J. Gary Seay, who retired. Throughout his career, Mr. Shah has also held information technology roles at Milwaukee-based Aurora Health Care, SymphonyIRI and Caremark Rx. He holds an MBA from the Illinois Institute of Technology and a master's in information technology from Roosevelt University, both located in Chicago.

Gene Shaw. CIO of Yuma (Ariz.) Regional Medical Center. Mr. Shaw was the first to be appointed CIO of Yuma Regional Medical Center more than 10 years ago. Mr. Shaw guided the development of the hospital's IT team and oversaw the implementation of the hospital's EHR system. Throughout Mr. Shaw's reign as CIO, the IT department grew from approximately two dozen staff members to more than 150 employees. Mr. Shaw is a fellow of the American College of Healthcare Executives and a CHIME fellow.

William Showalter. Senior Vice President and CIO of Froedtert Health (Milwaukee). Mr. Showalter was appointed CIO of Froedtert in August 2015. Prior to joining Froedtert, Mr. Showalter served as senior vice president and CIO of Mercy Health in St. Louis and CIO of Fairview Health Services in Minneapolis and also held various leadership roles within Seimens Health Services in Malvern, Pa. He holds a master's degree in planning, a master's degree in administration and a graduate certificate in information systems management from the University of Pittsburgh.

Preston Simons. CIO of Aurora Health Care (Milwaukee). Prior to joining Aurora Health Care in October 2015, Mr. Simons was CIO of Abbot Laboratories for more than a decade. There, he was responsible for a number of IT functions at the company's spinoff, AbbVie. Mr. Simons has served as an IT leader in several health systems, a health insurance plan and in the pharmaceutical industry, as well as a leading role in the Chicago CIO Institute. Mr. Simons has a master's degree from the Booth School of Business at the University of Chicago.

Alan Smith. Senior Vice President and CIO of Capella Healthcare. Mr. Smith joined Capella, one of the largest for-profit health systems in the U.S., in May 2011. Previously, he was vice president of applications and interim CIO of Vanguard Health Systems in Nashville. Mr. Smith has been involved with several professional organizations, including chairing the HIT Task Force of the Federation of American Hospitals. He earned a master's of public health degree from the University of North Carolina at Chapel Hill.

Ryan Smith. Senior Vice President and CIO of Banner Health (Phoenix). Mr. Smith joined Banner Health in October 2013 as senior vice president of information technology and CIO. Prior to his appointment at Banner, Mr. Smith worked for Intermountain Healthcare in Salt Lake City, where he led a number of IT initiatives, including operational accountability for all clinical and business applications and end-user computing and service management. Mr. Smith holds an MBA in IT management from Western Governor's University.

Steven Smith. CIO of NorthShore University HealthSystem (Evanston, Ill.). Prior to holding the CIO position at NorthShore, Mr. Smith served as chief technology officer of the health system for more than a decade. Under Mr. Smith's leadership, NorthShore University HealthSystem became one of the first healthcare systems in the country to achieve the HIMSS Analytics Stage 7 designation, and was recognized as one of *Hospitals & Health Networks*' 2013 "Most Wired" hospitals.

Subra Sripada. Executive Vice President, Chief Transformation Officer and System CIO of Beaumont Health (Royal Oak, Mich.). Prior to joining Beaumont Health after its creation in 2014, Mr. Sripada served in various roles at Beaumont Health System, including executive vice president, chief administrative officer and CIO. Before Beaumont, Mr. Sripada served in a leadership role at PricewaterhouseCoopers. He is a member of CHIME and serves on the board of the Michigan Health and Hospital Association and the Governor's Cyber Security Council. Mr. Sripada earned his master's degree in industrial and systems engineering from Kansas State University.

Joey Sudomir. Senior Vice President of Innovative Technology Solutions and CIO of Texas Heath Resources (Arlington). Mr. Sudomir joined Texas Health Resources in 2013 as vice president of IT operations and quickly worked his way through the ranks at the nonprofit health system. He was named deputy CIO in 2014, and the following year he was appointed senior vice president of innovative technology solutions and CIO. Mr. Sudomir joined Texas Health Partners, a department within Texas Health Resources, in 2008. There he led IT-related clinical transformation efforts for Texas Health's joint ventures. Under his leadership, all of Texas Health's joint venture hospitals achieved meaningful use.

Phyllis Teater. CIO and Associate Vice President of The Ohio State University Wexner Medical Center (Columbus). Ms. Teater joined The Ohio State University Wexner Medical Center, Central Ohio's only academic medical center, in 1991. She was appointed CIO of the hospital in October 2010, after serving as its interim CIO. Under her leadership, Wexner achieved HIMSS Analytics Stage 7. The hospital also made *U.S. News & World Report's* 2015-16 list of the Most Connected Hospitals.

Tim Thompson. Senior Vice President and CIO of BayCare Health System (Clearwater, Fla.). Mr. Thompson has served as CIO of BayCare since September 2010. Prior to that, he was senior vice president and CIO of Methodist Hospital System in Houston. At Methodist, Mr. Thompson launched a health information exchange. He also previously held the CIO role at both Adventist Health System in Altamonte Springs, Fla., and Palmetto Health in Columbia, S.C. He earned his bachelor's degree from the University of Illinois and is a member of CHIME and HIMSS.

Lac Van Tran. Senior Vice President, Associate Dean and CIO of Rush University Medical Center (Chicago). Mr. Tran has had the title of CIO for two decades. He assumed his position at Rush, a 664-bed hospital, in 2002. Prior to Rush, Mr. Tran served as CIO of various hospitals and health systems, including Methodist Hospital System in Houston, Boston Children's Hospital and Brook (N.Y.) Medical Center.

Joel Vengco. Vice President and CIO of Baystate Health (Springfield, Mass.). Mr. Vengco has served as CIO of nonprofit Baystate since 2012. He's credited with launching TechSpring, Baystate's health technology innovation center, in 2013. Many tech startups have partnered with TechSpring for product development, including CarePort Health and Medecision. Prior to joining Baystate, Mr. Vengco served as vice president and general manager at one of the businesses that makes up GE's healthcare IT business.

John Ward. CIO of TriHealth (Cincinnati). After serving as interim CIO, Mr. Ward was appointed CIO of TriHealth in May 2014. He previously served as director of business development at Group Health Associates, a physician partner group of TriHealth. Mr. Ward also served as director of health systems integration and director of ambulatory systems for TriHealth. He is a member of CHIME and HIMSS.

David Weiss. Senior Vice President and CIO of BJC HealthCare (St. Louis). Mr. Weiss has served as CIO of nonprofit BJC HealthCare since 1990. As CIO, Mr. Weiss is responsible for planning, developing and supporting information technology and telecommunications initiatives throughout BJC's hospitals and service organizations. He also serves as chairman of the Telecommunication Facilities Corp., a joint venture between BJC HealthCare and the Washington School of Medicine. Mr. Weiss is a member of HIMSS.

Deanna Wise. Executive Vice President and CIO of Dignity Health (San Francisco). Ms. Wise has served as CIO of Dignity Health since 2011, and she previously served in the CIO role at four other health systems. At Dignity, Ms. Wise is responsible for all IT functions with particular focus on implementing the health system's EHR software. Before joining Dignity, Ms. Wise served as senior vice president and CIO of Nashville, Tenn.-based Vanguard Health Systems, which merged with Dallas-based Tenet Healthcare in 2013.

Eric Yablonka. Vice President and CIO of University of Chicago Medicine and Biological Sciences. With more than 25 years of experience in leading hospital operations and information systems management functions, Mr. Yablonka has served as vice president and CIO of University of Chicago Medical Center and Biological Sciences since August 2001. He is responsible for overseeing all information technology functions, biomedical engineering and the call center. Prior to joining University of Chicago Medicine, Mr. Yablonka was vice president and CIO of Saint Raphael Healthcare System in New Haven, Conn. ■

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Carolinas HealthCare Plans $3B in Capital Investments

By Ayla Ellison

Charlotte, N.C.-based Carolinas HealthCare System intends to spend $3 billion on capital projects as part of a six-year reinvestment plan, according to a *Charlotte Observer* report.

At the health system's quarterly board meeting, Greg Gombar, CFO of Carolinas HealthCare, said the plan is critical to meet evolving consumer demands when it comes to healthcare.

Mr. Gombar said it is the health system's goal to spend 10 percent of net operating revenue annually on capital projects, including buildings and technology.

Since 1984, Carolinas HealthCare has spent an average of 11 percent of net operating revenue annually on capital projects. However, the health system had pulled back on its capital investments in recent years, according to the report.

Mr. Gombar didn't provide details on any future projects, but Carolinas HealthCare CEO Michael Tarwater said at least one project will be announced in early 2016. ■

OSU Wexner's Operating Margin Cut in Half on CFO's Recommendation

By Ayla Ellison

In the healthcare industry, where median nonprofit hospital margins have been in the 2 percent to 3 percent range for the past few years, Columbus-based The Ohio State University Wexner Medical Center stood out with double-digit margins.

However, Mark Larmore, who took over as Wexner's CFO Oct. 1, recently cut the annual operating margin reported to trustees in half, according to a *Columbus Business First* report.

Wexner reported a 13.7 percent operating margin for the fiscal year that ended June 30, but that number didn't account for about $130 million used to support OSU's medical school and to pay faculty physicians for their time training students and newly licensed physicians in residency programs, according to the report.

In a recent summary to trustees, Mr. Larmore said that after the support to the medical school was accounted for, Wexner ended FY 2015 with a healthy 7 percent operating margin. Regarding why the hospital made the change, Mr. Larmore told *Columbus Business First*, "We thought the board should see it, including the cost the health system is incurring to support the mission." ■

Brigham Reports $53M Shortfall After Epic Transition

By Brooke Murphy

Boston-based Brigham and Women's Hospital reported its first budget shortfall in more than 15 years for the fiscal year that ended Sept. 30.

The hospital came $53 million short of its budget, owing the shortfall in part to unexpected costs associated with its EHR transition in June, hospital spokeswoman Erin McDonough told *STAT*.

The EHR transition – part of a broader Epic implementation across 10 Boston-based Partners HealthCare hospitals – cost Brigham $27 million more than its $47 million cost estimation.

The hospital had planned for a $122 million surplus in the most recent fiscal year, which was to be reinvested into capital projects. Financial problems prompted the hospital to lay off 20 workers and eliminate 80 vacant job positions earlier this year, according to Ms. McDonough.

Improperly coded patient visits resulted in lower reimbursements from insurance companies, estimated at $13.5 million of the $27 million excess costs. The other half came from reduced patient volume this past summer in an attempt to avoid miscoding.

Brigham and Women's Hospital President Betsy Nabel, MD, said the Epic-related losses and coding problems are expected to be temporary, according to *STAT*.

Epic spokeswoman Erika Koch told STAT that while there are initial financial investments in launching the company's software, "what we typically see when a health system transitions to Epic is permanent, long-term improvement in financial health and increased bond ratings." ■

Moody's: High Rate of Physician Employment Linked to Lower Profitability

By Tamara Rosin

Nonprofit and public hospitals and health systems with very high rates of physician employment showed stronger revenue growth but lower profitability than those with lower employment rates, according to Moody's Investor Service's Physician Employment FY 2014 Medians report.

Moody's predicts this dynamic will persist for several years as hospitals continue employing greater numbers of physicians.

For its analysis, Moody's divided hospitals into four categories based on employed physicians as a percentage of the total medical staff:

- Low: 1 to 15 percent
- Mid: >15 to 30 percent
- High: >30 to 65 percent
- Very High: >65 to 100 percent

Here are four key findings from Moody's report.

1. Very high levels of physician employment quell margins. The median operating cash flow margin is 10.7 percent for hospitals with low physician employment, compared to 8.5 percent for hospitals with very high physician employment.

2. Physician employment contributes to higher revenue and expense growth. Hospitals with very high rates of physician employment have higher revenue and higher expense growth as they absorb physician salaries and make related IT investments and staffing changes.

This is evidenced by a 6.8 percent three-year revenue compound annual growth rate and 7.5 percent expense CAGR for hospitals with very high employment rates. Hospitals with low physician employment, on the other hand, had a median of 4.9 percent and 5 percent, respectively. "While we expect expense growth to slow as hospitals generate efficiencies through better practice management and economies of scale, direct losses on physician practices will remain a challenge," Moody's analysts noted.

3. Operating revenue for hospitals with very high physician employment vastly exceeds the U.S. median total operating revenue. Hospitals with very high physician employment have a median operating revenue of $950 million compared to $431 million for hospitals with low employment and $673 million for the national median.

4. Hospitals with very high physician employment report greater outpatient revenue than inpatient revenue. Hospitals that employ a high volume of physicians report a greater share of outpatient revenue (54 percent) than inpatient revenue (46 percent), nearly the exact inverse for hospitals with low employment rates. ■

Fitch Predicts Profitability Obstacles for US Hospitals in 2016: 5 Things to Know

By Emily Rappleye

Fitch Ratings expects margins for the largest U.S. for-profit hospital companies to be under pressure in 2016, due to some profitability challenges from last year as well as new challenges in the coming year.

Here are five things to know about Fitch's projections, as presented by *Reuters*.

1. U.S. for-profit hospital companies reported an average 2 percent growth in patient volumes in the third quarter of 2015, but this did not translate into growth in operating margins. The lack of positive impact on operating margins marks a reversal in year-over-year improved operating margins in the last few quarters, according to the report. In the third quarter of 2015, the largest U.S. for-profit hospital companies reported an average operating EBITDA margin up just 16 basis points over the same period last year, and many reported significant decline in same hospital margins, according to the report.

2. Several factors hindered profitability in 2015, though Fitch expects many to be short-lived. These factors include higher labor and supply expenses, weak growth in pricing and higher levels of uncompensated care. Acute care hospitals felt the benefits of the Affordable Care Act in early 2015, according to Fitch, but it is still too early to determine if the increase in uncompensated care in late 2015 was due to a tapering of the law's benefits.

3. Fitch projected a few of these challenges to carry over in 2016, and a few new headwinds to add to financial pressures. The commercial viability of the public health insurance exchanges and slow progress in Medicaid expansion will stall the benefits of the ACA in 2016, according to Fitch. New potential challenges include presidential election-cycle politicking and ACA news flow, which could both impact equity prices and capital deployment priorities for hospital companies in the coming year.

4. Recent acquisitions provide an opportunity for hospital companies to pay down debt. Some companies continue to have high leverage from recent acquisitions, according to Fitch. "Good operating cash flow generation and proceeds from asset sales will provide an opportunity to pay down debt over the next several quarters," the report reads. Nonetheless, Fitch predicts cash will most likely be funneled back into acquisitions and share repurchases next year.

5. Where companies invest will determine their upward rating momentum in 2016. According to Fitch, most hospital companies have some buffer room under negative rating triggers, but these capital deployment decisions – payment of down debt versus acquisitions and share repurchases – will likely determine upward ratings. ■

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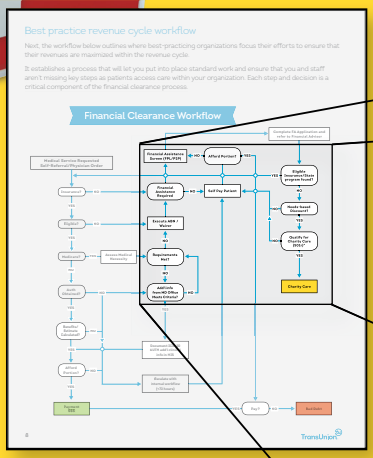

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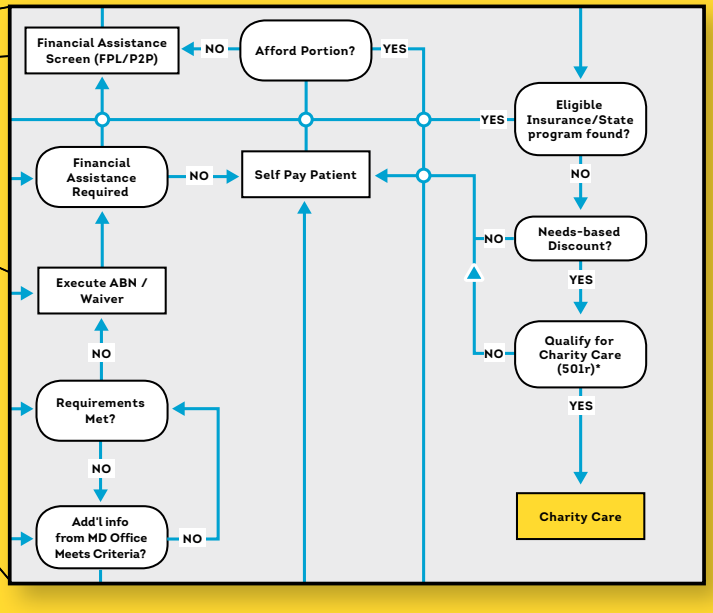

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Essential Skills of a Health System CFO: 3 Finance Chiefs Weigh In

By Ayla Ellison

The role of the hospital and health system CFO is evolving to encompass far more than crunching numbers. Healthcare finance chiefs are taking on more strategic roles that require a combination of analytical skills and people skills.

The shift in the CFO role is clear, with 52 percent of CFOs, including those from hospitals and health systems, spending more time on strategic issues, according to the Bank of America Merrill Lynch 2015 CFO Outlook survey.

The role of health system finance chief requires a different skill set than in the past. *Becker's Hospital Review* had the opportunity to catch up with three financial leaders from hospitals and health systems who weighed in on the essential skills a health system CFO needs to be successful in today's healthcare market.

Rhonda Anderson
Vice President and CFO, Ascension (St. Louis)

Amy Floria
CFO, IU Health Goshen (Ind.) Hospital

Daniel Morissette
CFO, Stanford (Calif.) Health Care

Rhonda Anderson, senior vice president and CFO, Ascension (St. Louis): "As the healthcare industry moves to a fee-for-value payment system, CFOs have to be open to the disruptive environment and look at the ongoing changes as an opportunity. To respond to this landscape, CFOs should be comfortable and flexible with seeking strategic partnerships and building relationships with other providers, health systems and payers."

Amy Floria, CFO, IU Health Goshen (Ind.) Hospital: "Health system CFOs must be strategic in thought and nimble in action. We must think three and four steps ahead due to the pace of change in healthcare. The pace is exhausting but CFOs must be nimble and proactively respond to anticipated changes without deviating from the system's key strategic objectives. In addition, a CFO must be an excellent communicator and be able to explain the path the system is navigating. We need to be able to explain the 'why' behind the system's strategy."

Daniel Morissette, CFO, Stanford (Calif.) Health Care: "A CFO still must have strong technical skills and experience in this complex healthcare environment. Additionally, strong communication skills, demonstrated success partnering with physicians and other executives, and examples of creativity in decision-making are equally important. The role of the CFO is clearly evolving, and the combination of strong analytical skills and people skills is more important than ever." ■

NorthShore CEO: FTC Gerrymandered to Oppose System Merger

By Ayla Ellison

Evanston, Ill.-based NorthShore University HealthSystem CEO Mark Neaman has accused the Federal Trade Commission of gerrymandering, claiming the agency is only analyzing a small portion of the Chicago area's healthcare market to challenge NorthShore's merger with Downer's Grove, Ill.-based Advocate Health Care, according to the *Chicago Tribune*.

In December, the FTC authorized action to block the planned NorthShore-Advocate merger, and the Illinois Attorney General joined the FTC in the matter. The deal was subsequently halted when both hospital chains and the FTC agreed to a temporary restraining order to stop the transaction.

In an administrative complaint, the FTC claimed if NorthShore and Advocate combined they would operate a majority of the hospitals in the combined system's competitive geographic market, composed of northern Cook and southern Lake counties.

However, Mr. Neaman claimed the FTC isn't looking at the full picture. In a meeting with the Tribune's editorial board, Mr. Neaman said the combined entity would compete with hospitals throughout Chicagoland, not just in northern Cook and southern Lake counties, and it would have 22 percent of inpatient beds in the six-county Chicago area market.

Mr. Neaman also took issue with the FTC's exclusion of some very close competitors in its analysis. For instance, the agency did not include Presence St. Francis Hospital in Evanston in its analysis, even though the hospital is only a few miles from one of NorthShore's hospitals.

"It seems kind of strange that you can gerrymander something like this and think for a moment that somebody can't drive from north Evanston to south Evanston," Mr. Neaman told the Tribune's editorial board. "And yet, with all of their work to try to come up with this geography, which suits their purposes, they had to work really, really, really, really hard to get it to just over 50 percent."

Although the antitrust battle could take months to resolve, both Advocate and NorthShore have said they remain committed to the deal and will fight the FTC's attempt to prevent the transaction, according to the report. ■

The Meaning in Aetna's Departure from AHIP

By Erin Marshall

After Aetna announced plans to leave America's Health Insurance Plans Jan. 5, sources have curiously evaluated the decision and its impacts.

Created in 2003 due to a merger between the Health Insurance Association of America and the American Association of Health Plans, AHIP is currently the health insurance industry's largest trade group. But the organization has seen numerous problems in recent years, sources claim.

Karen Ignagni, AHIP's CEO for 22 years, left the trade group in 2015, as did two other senior officials – Mary Beth Donahue, former executive vice president, and Dan Durham, former executive vice president for strategic initiatives and interim CEO.

Aetna's exit from AHIP, combined with UnitedHealthcare's departure in June, leave AHIP without some needed member dues. AHIP earned $41.5 million in member dues in 2014, according to the report. Aetna paid approximately $1.1 million in dues each year, according to *The Hill*.

The rapid departure of insurers from AHIP has left some analysts puzzled. "With Aetna and [UnitedHealthcare] facing such tough regulatory scrutiny, it seems silly that they would abandon one of D.C.'s most powerful trade organizations. They are putting their brand at risk," an anonymous industry source told *The Hill*.

According to *The Hill*'s other sources, the AHIP's larger members have recently felt distanced from the trade group's leadership.

Still others believe AHIP has nothing to fear. "AHIP is going to continue to speak for the industry, that's just what's going to happen," said Dan Mendelson, founder and CEO of Avalere Health and a former Clinton administration advisor.

"Let's be real, when Sylvia Burwell wants to find out what the health insurance industry's position is on an issue, she's going to call Marilyn Tavenner. She's not going to call the CEO of any one member company," he added. ■

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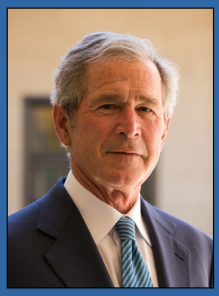
David Feinberg
MD, President and Chief Executive Officer, Geisinger Health System

Howard Dean
MD, Former Chairman, Democratic National Committee and Governor of Vermont (Keynote Panelist)



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43rd President of the United States of America

Chris Van Gorder
FACHE, President and Chief Executive Officer, Scripps Health

John Noseworthy
MD, President and Chief Executive Officer, Mayo Clinic

Nancy Howell Agee
President and Chief Executive Officer, Carilion Clinic (Keynote Panelist)

Joel Allison
Chief Executive Officer, Baylor Scott & White Health

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Founder, Studer Group

Teri Fontenot
FACHE, President and Chief Executive Officer, Woman's Hospital (Keynote Panelist)

Session Tracks

- **Track A** - CEO, Strategy and ACO Issues
- **Track B** - ACOs, Population Health, Affiliation and Other Issues
- **Track C** - Physician-Hospital Alignment
- **Track D** - Patient Safety and Quality Issues
- **Track E** - CFO and Financial Issues
- **Track F** - Revenue Cycle Management Issues
- **Track G** - Health Information Technology Issues
- **Track H** - Thought Leaders

KEYNOTE PANELISTS

Barry Arbuckle
PhD, President and Chief Executive Officer, MemorialCare Health System

Peter Butler
President, Rush University Medical Center

Michael Dowling
President and Chief Executive Officer, North Shore-Long Island Jewish Health System

Steven Goldstein
President and Chief Executive Officer, Strong Memorial Hospital

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Randy Oostra
DM, FACHE, President and Chief Executive Officer, ProMedica

Michael Rowan
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Chief Executive Officer, Henry Ford Health System

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President and Chief Executive Officer, Capella Healthcare

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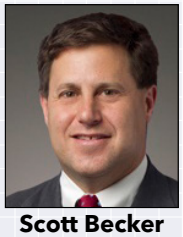

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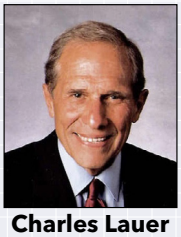

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Author, Consultant, Speaker, Former Publisher, *Modern Healthcare*

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2:00 - 5:45 pm	Sessions
5:45 - 6:45 pm	Networking Reception

Thursday, April 28, 2016

7:00 - 8:00 am	Registration & Continental Breakfast
8:00 - 9:25 am	Sessions
9:25 - 9:50 am	Networking Break in Exhibit Hall
9:50 - Noon	Sessions
Noon - 1:00 pm	Networking Luncheon
1:00 - 3:10 pm	Sessions
3:10 - 3:30 pm	Networking Break in Exhibit Hall
3:30 - 5:00 pm	Sessions
5:00 - 7:00 pm	Cocktail Reception in Exhibit Hall

Friday, April 29, 2016

7:00 - 8:00 am	Registration & Continental Breakfast
8:00 - 11:00 am	Sessions
11:00 - 11:20 am	Networking Break in Exhibit Hall
11:20 - 12:45pm	Sessions
12:45 - 1:45 pm	Networking Luncheon
1:45 - 3:10 pm	Sessions
3:10 - 3:30 pm	Networking Break in Exhibit Hall
3:30 - 5:00 pm	Sessions
5:00 - 6:00 pm	Cocktail Reception in Exhibit Hall

Saturday, April 30, 2016

7:00 - 8:00 am	Continental Breakfast
8:00 - 9:25 am	Sessions
9:25 - 9:45 am	Networking Break
9:45 - Noon	Sessions

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Registration

2:00 - 2:40 pm

A. Winning the Hearts and Minds of Physicians in Value-Based Care
- Frank Williams, Chief Executive Officer and Co-Founder, Evolent Health

2:45 - 3:25 pm

A. Transform Healthcare by Transforming Leadership
- Michael Arena, PhD, Chief Talent Officer, General Motors
- Mary Uhl-Bien, BNSF Endowed Professor, Leadership, Texas Christian University
- Jay Herron, Partner, Royer Maddox Herron Advisors

B. The Dramatic Impact of Relationship-Based Care on Population Health Outcomes
- Steve Tierney, MD, Medical Director, Quality Improvement and Chief Medical Information Officer, Southcentral Foundation
- Karen McIntire, Director, Organizational Development, Southcentral Foundation
- David Labby, MD, PhD, Chief Medical Officer, Health Share of Oregon
- Moderated by Martin Schreiber, EdD, Vice President, Mission, Mercy Fort Smith

C. Care Management: What ACO Operators Need to Know
- Luke Peterson, Principal, Health System Advisors
- Heather Smith, Vice President, Clinical Integration, Integrated Health Network of Wisconsin

D. Discretionary Effort Leadership: Moving Employees from Minimal Effort to Amazing Contributions
- Greg Stock, Chief Executive Officer, Thibodaux Regional Medical Center
- Karla Brandau, Chief Executive Officer, Workplace Power Institute

3:30 - 4:10 pm

A. Developing an Intelligent Enterprise: You Can't Change What You Can't Measure
- Herbert White, Assistant Vice President, Finance, Temple University Health System
- Jayne Bang, Director, Finance Project Development, Temple University Health System
- Christopher Snyder, Director, Business Intelligence, Temple University Health System

B. Making Healthcare Affordable for the Patient: An Enterprise Cost and Efficiency Approach
- Edmund Sabanegh, MD, Chairman, Urology, Vice Chairman, Clickman Urological and Kidney Institute and Director, Center for Male Fertility, Cleveland Clinic
- Michael Phillips, MD, Director, Center for Business Development, Imaging Institute, Cleveland Clinic
- Linda McHugh, MT, Executive Administrator, Cleveland Clinic

C. The Promise and Peril of Data Analytics
- David Muhlestein, PhD, JD, Senior Director, Research and Development, Leavitt Partners

D. Reduce Investment Risk Using Efficient Frontier, Monte Carlo and Tail Risk Strategies
- George Cook, CIMA, AIF, Managing Director, Institutional Consultant, Graystone Consulting
- Larry Ekstrom, CIMA, Executive Director, Institutional Consultant, Graystone Consulting
- Tom Crook, Vice President, Treasury Services, Essentia Health

4:10 - 4:55 pm

A. Co-opetition Among Hospitals
- Cindy Bo, Chief Strategy and Business Development Officer, Nemours/Alfred I. duPont Hospital for Children

B. Achieving Success with Direct Employer Contracts in the New Retail Healthcare Market: An "Outside the Box" Approach
- Bill Eggbeer, Managing Director, Payer-Provider Innovation Practice, BDC Advisors
- Craig Enge, Chief Operating Officer, Providence-Swedish Health Alliance

C. Analytic-Driven Quality: Keys for Success in Risk-Based Contracts
- Brian Rice, Vice President, Network/ACO Integration, Allina Health
- Ross Gustafson, Vice President, Allina Performance Resources, Allina Health; Vice President, Health Catalyst

D. Using Analytics to Drive Down

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Costs and Improve the Patient Experience in the OR
- Amit Jiwani, Director, Analytics, Surgical Information Systems

5:00 - 5:45 pm

A. KEYNOTE PANEL — Key Strategies and Trends for 2016-2017
- Peter Butler, President, Rush University Medical Center
- Steve Little, President and Chief Executive Officer, Agnesian HealthCare
- Thomas Sadvary, FACHE, Chief Executive Officer, HonorHealth
- Nancy Schlichting, Chief Executive Officer, Henry Ford Health System
- Michael Wiechart, President and Chief Executive Officer, Capella Healthcare
- Moderated by Charles Lauer, Author, Consultant, Speaker, Former Publisher, *Modern Healthcare*

Thursday, April 28, 2016

Concurrent Sessions:

Track A - CEO, Strategy and ACO Issues
Track B - ACOs, Population Health, Affiliation and Other Issues
Track C - Physician-Hospital Alignment
Track D - Patient Safety and Quality Issues
Track E - CFO and Financial Issues
Track F - Revenue Cycle Management Issues
Track G - Health Information Technology Issues
Track H - Thought Leaders

7:00 - 8:00 am
Continental Breakfast in the Lobby

8:00 - 8:40 am

A. The Biggest Issues and Best Opportunities in Healthcare for 2016
- Howard Drenth, President and Chief Executive Officer, Presence Medical Group
- Randy Oostra, DM, FACHE, President and Chief Executive Officer, ProMedica
- Nish Patel, Chief Executive Officer, Women's Hospital
- Gregg Beeg, FACHE, Chief Financial Officer, Oaklawn Hospital
- Moderated by Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Educator, Author, Managing Healthcare Reform: Ideas for Leaders

B. M&A Provider Panel: Integration Trends, Best Practices and Post Integration Opportunities
- Liz Foshage, Senior Vice President Finance, Ascension Health
- Scott Nordlund, Executive Vice President, Growth, Strategy and Innovation, Trinity Health
- Moderated by Brent McDonald, Managing Director and Head, Healthcare Strategic Services, Bank of America Merrill Lynch

C. The Evolution of ASCs and Physician-Hospital Joint Ventures
- Joseph Zasa, JD, Managing Partner, ASD Management
- Jeff Simmons, Chief Development Officer, Regent Surgical Health
- Luke Lambert, CFA, CASC, Chief Executive Officer, Ambulatory Surgery Centers of America
- Vince Kickirillo, CFA, CVA, Managing Director, VMG Health
- Moderated by Scott Becker, JD, CPA, Publisher, Becker's Healthcare; Partner, McGuireWoods LLP

D. Patient and Family Experience
- Scott Ellner, DO, FACS, President, Saint Francis Medical Group; Vice Chairman, Surgery and Director, Surgical Quality, Saint Francis Hospital and Medical Center
- Marion Martin, Chief Operating Officer, Center for Quality and Patient Safety and Experience Officer, Roper St. Francis
- Sue MacInnes, Chief Market Solutions Officer, Medline Industries, Inc.
- Alison Tothy, MD, Chief Experience Officer, Engagement Officer and Associate Professor, Pediatrics, Section, Pediatric Emergency Medicine, University of Chicago Medicine
- Moderated by Heather Punke, Managing Editor, Becker's Healthcare

E. Key Financial and Alignment Strategies
- Mark Bogen, Chief Financial Officer, South Nassau Communities Hospital
- Matthew Sells, Chief Financial Officer, Shenandoah Medical Center
- John Orsini, CPA, Senior Vice President and Chief Financial Officer, Northwestern Memorial HealthCare
- Pat McGuire, Chief Financial Officer, St. John Providence Health System
- Moderated by Carrie Pallardy, Editor, Becker's Healthcare

F. The Best Actions to Improve Revenue Now: What is Working
- Mark Baker, Chief Executive Officer, Hughston Clinic and Jack Hughston Memorial Hospital
- Cheryl Sadro, CPA, MSM, Executive Vice President and Chief Business and Finance Officer, The University of Texas Medical Branch
- Moderated by Barton Walker, JD, Partner, McGuireWoods LLP

G. The Promise of Big Data
- David Chou, Global Digital Healthcare Advisor and Former Chief Information Officer, University of Mississippi Medical Center
- Michael Hunt, DO, FACOP, Chief Medical Officer and Chief Medical Information Officer, St. Vincent's Health Partners, Inc.
- Eric Yablonka, Vice President and Chief Information Officer, The University of Chicago Medicine and Biological Sciences
- Joel Vengco, Vice President and Chief Information Officer, Baystate Health
- Moderated by Holly Carnell, JD, Associate, McGuireWoods LLP

8:45 - 9:25 am

A. Unique Strategies to Provide Excellent Care in Rural Markets
- Raymond Christensen, MD, Gateway Family Health Clinic, University of Minnesota; 2014 President, National Rural Health Association
- Sean Fadale, Chief Executive Officer, Community Memorial Hospital
- David Keith, President and Chief Executive Officer, McAlester Regional Health Center
- Robin Rose, Chief Operating Officer, Gibson Area Hospital and Health Center; Board Member, Illinois Rural Health Association
- Moderated by Kate Carow, FACHE, Principal, Carow Consulting

B. A Seven-Step Approach to a Clinically Integrated Network
- Gayle Capozzalo, FACHE, Executive Vice President, Strategy and System Development, Yale New Haven Health System
- Megan North, President, Value-Based Care Business Unit, Conifer Health Solutions

C. Financial and Strategic Perspective on Physician Alignment
- Pamela Hess, CPA, Chief Financial Officer, St. Thomas Midtown and St. Thomas West Hospitals
- Tony Tedeschi, MD, Chief Executive Officer, Weiss Memorial Hospital; Chief Medical Officer, Tenet Northeast Region - Chicago Market
- Jerry Burgess, Chief Corporate Responsibility Officer, Amita

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Health
- Moderated by Gail Peace, President and Chief Executive Officer, Ludi

D. Less Cost, More Value from Your Workforce
- Karlene Kerfoot, PhD, RN, NEA-BC, FAAN, Chief Nursing Officer, API Healthcare

E. The Most Important Issues for CFOs Today
- Robin Norman, Senior Vice President and Chief Financial Officer, Virginia Hospital Center
- James Porter, Chief Financial Officer, St. Bernard Hospital
- Moderated by Scott Becker, JD, CPA, Publisher, Becker's Healthcare; Partner, McGuireWoods LLP

F. From Volume to Value: Building the Bridge While You Cross It
- Bob Finuf, Vice President, Payor Relations and Executive Director, Children's Mercy, Integrated Care Solutions
- Jill Anderson, Senior Strategist, Revenue Cycle, Cerner Corp.

G. Data-Enabled Strategic Resource Allocation
- Tina Esposito, Vice President, Center for Health Information Services, Advocate Health Care
- Rishi Sikka, MD, Senior Vice President, Clinical Transformation, Advocate Health Care

H. Innovative Alignments for Service Expansion in a Competitive Market: How We Expanded Access to Patient Care
- Chris Thomas, FACHE, President and Chief Executive Officer, Colorado West Healthcare System, Community Hospital
- David J. Murray, CCEP, CHPC, Chief Compliance Officer and Chief Innovation Officer, Colorado West Healthcare System
- Connie Mack, Vice President, Business Development, Colorado West Healthcare System

9:25 - 9:50 am
Networking Break

9:50 - 10:30 am

A. Sell Our Community Hospital? Not so fast!
- Arthur A. Gianelli, President, Mount Sinai St. Luke's
- George Kerwin, President and Chief Executive Officer, Bellin Health
- John Schon, Administrator/Chief Executive Officer, Dickinson County Healthcare System
- Moderated by Joseph Lupica, JD, Chairman, Newpoint Healthcare Advisors

B. A Survey Look at the Evolving Stages of Population Health and ACOs
- George Mayzell, MD, Chief Medical Officer and Chief Transformation Officer, Adventist Midwest Health
- Gyasi Chisley, Chief Executive Officer, Methodist Healthcare North; Senior Vice President, Methodist Le Bonheur Healthcare
- Dennis Shelby, Chief Executive Officer, Wilson Medical Center
- Roy Proujansky, MD, Chief Executive Officer, Nemours Delaware Valley Operations; Executive Vice President, Health Operations, Nemours
- Moderated by Brian Silverstein, MD, Managing Partner, HC Wisdom

C. Hospital Physician Alignment: Key Strategies to Succeed
- Jeffrey Fried, FACHE, President and Chief Executive Officer, Beebe Healthcare
- Abha Agrawal, MD, FACP, Chief Operating Officer and Chief Medical Officer, Norwegian American Hospital
- R. Edward Howell, Former Vice President and Chief Executive Officer, University of Virginia Medical Center
- Barbara Martin, FACHE, Chief Executive Officer, Vista Health System
- Moderated by Tamara Rosin, Writer, Becker's Healthcare

D. Using Quality and Patient Safety to Improve Financial Results
- Carey Albright, RN, CENP, Administrative Director, Ortho-Neuro/Med-Surg Services, Maury Regional Medical Center
- Verette Neeb, Chief Nursing Officer, Baylor Medical Center Uptown
- Denise Majeski, RN, ACM, NE-BC, Vice President, Operations and Chief Nurse Executive, Northwestern Medicine, Lake Forest Hospital
- William Munley, Vice President, Orthopaedics, General Surgery and Professional Services, Bon Secours St. Francis Health System
- Moderated by Carrie Pallardy, Editor, Becker's Healthcare

E. Key Thoughts on Allocating Capital
- Pamela Hess, CPA, Chief Financial Officer, St. Thomas Midtown and St. Thomas West Hospitals
- Robin Norman, Senior Vice President and Chief Financial Officer, Virginia Hospital Center
- Joseph Pedley, CPA, Vice President and Chief Financial Officer, Lawrence Memorial Hospital
- Moderated by Heather Punke, Managing Editor, Becker's Healthcare

F. Hospital/Physician RCM Integration
- Matthew Michaels, President, Hospital RCM, Conifer Health Solutions
- Charles Handley, Chief Financial Officer, Providence Memorial

G. Telemedicine and System Integration
- Dan Kinsella, Leading Chief Information Officer Consultant
- Alan Papa, FACHE, President and Chief Operating Officer, Akron General Health System
- Moderated by Ayla Ellison, JD, Finance Editor, Becker's Healthcare

H. Improving Health Outcomes in Rural America: New Facility Design, New Care Model and Improved Outcomes
- Michael Lutes, Senior Vice President, Carolinas Healthcare System

10:35 - 11:15 am

A. The Hospital CEO's Ultimate Dashboard: What to Check Each Day, Quarter and Year
- Bernard Wheatley, DBA, FACHE, Chief Executive Officer, Schneider Regional Medical Center
- Austin Okogun, MD, Chief Executive Officer, Lily Hospitals
- Don Lovasz, President and Chief Executive Officer, KentuckyOne Health Partners, LLC
- Arturo Polizzi, President, ProMedica Toledo Hospital and Toledo Children's Hospital
- Moderated by Molly Gamble, Editor-in-Chief, Becker's Healthcare

B. Value-Based Reimbursement Contracting: Strategies for Payer-Provider Success
- James Wright, Vice President, Business Development, xG Health Solutions

C. Physician Employment Models: Strategies for Success
- David DiLoreto, MD, System Senior Vice President and Chief Medical Officer, Presence Health
- John Sheehan, FACHE, President, UW Health, The American Center; Senior Vice President, UW Health
- Steven Docimo, MD, Chief Medical

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Officer and Vice President, Children's Subspecialty Services; Professor, Pediatric Urology, Children's Hospital of Pittsburgh of UPMC
- Tony Tedeschi, MD, Chief Executive Officer, Weiss Memorial Hospital; Chief Medical Officer, Tenet Northeast Region - Chicago Market
- Moderated by Brian Silverstein, MD, Managing Partner, HC Wisdom

D. Healthcare Reform and Revamping the Role of the CNO
- Gemma Rama-Banaag, RN, Chief Nursing Officer, Paradise Valley Hospital
- Moderated by Rosemary Plorin, President and Chief Executive Officer, Lovell Communications, Inc.

E. Transforming Your Inpatient Care Model to Support Value Based Care: $10 Million Saved While Outcomes Improved
- Brian Sweeney, RN, FACHE, Senior Vice President, Hospital Operations, Thomas Jefferson University Hospitals

F. What Metrics Should You Measure to Determine the Effectiveness of Your RCM Solution?
- T. Scott Law, Founderand Chief Executive Officer, Zotec Partners

G. Expanding and Integrating Emergency Care in the Valley
- Don Adam, Chief Development Officer, Adeptus Health

H. Eliminating Inefficiencies to Enable Better, Cost-Efficient Care
- Ed Park, Chief Operating Officer, athenahealth
- Brett Reed, Chief Executive Officer, Cohealo

11:20 - 12:00 pm

KEYNOTE
- Joel Allison, Chief Executive Officer, Baylor Scott & White Health

12:00 - 1:00 pm
Networking Luncheon

1:00 - 1:40 pm

A. Strategy: Thinking 5 Years Into the Future
- Thomas "Tim" Stover, MD, President and Chief Executive Officer, Akron General Health System
- Anthony Armada, FACHE, Chief Executive Officer, Swedish Healthcare
- Sherri Luchs, Chief Administrative Officer, Penn State Hershey Medical Group
- Moderated by Charles Lauer, Author, Consultant, Speaker, Former Publisher, *Modern Healthcare*

B. Strategies to Improve Population Health
- Dale Beatty, Chief Nursing Officer, University of Illinois Medical Center
- Kathy Ferket, Vice President, Clinical Transformation, Amita Health
- Stonish Pierce, FACHE, Regional Chief Ambulatory and Ancillary Officer, Presence Health
- Moderated by Kate Carow, FACHE, Principal, Carow Consulting

C. Different Thoughts on Physician Hospital Engagement and Integration
- Jeff Hill, Regional Vice President, Quorum Health Resources
- Emmett Schuster, President and Chief Executive Officer, Gibson General Hospital
- Steve Little, President and Chief Executive Officer, Agnesian HealthCare
- Moderated by Laura Dyrda, Editor-in-Chief, Becker's Healthcare

D. How Better Performing Health Systems are Reinventing Perioperative Services and Proving Value to Payors, Patients and Surgeons
- Jeffry Peters, President, Surgical Directions
- Tom Blasco, MD, Medical Director, Illinois Sports Medicine and Orthopedic Surgery Center

E. The Large Employer Opportunity: How Progressive Health Systems can Serve their Needs to Generate Mutual Value
- Peter Bresler, North America Practice Leader, Health Analytics, Willis Towers Watson

F. Improving Business Processes to Effectively Collect in a Consumer World
Suzanne Lestina, FHFMA, CPC, Vice President, Revenue Cycle Innovation, Avadyne Health

G. Best Practices for an Effective Patient Advocacy Program
- Julie Kay, Vice President, Solution Consulting, Adreima
- Jerry Thompson, Director, Patient Access, Baptist Hospitals of Southeast Texas

H. The Group Practice: Our Foundation, Our Future
- Robert Wolterman, Chief Executive Officer, Ochsner Medical Center
- Beth Walker, Chief Operating Officer, Ochsner Medical Center
- Robert Hart, MD, Regional Medical Director, Ochsner Medical Center

1:45 - 2:25 pm

A. The Best Ideas for ACOs, PHOs and Shared Savings Agreements
- Michael Swarzman, Vice President, Business Development and Service Lines, Advocate Illinois Masonic Medical Center
- Denyse Traeder, Chief Executive Officer, Frontier Rural Health Network
- H. Scott Sarran, MD, Chief Medical Officer, Government Program Health Care Service Corporation
- Moderated by Molly Gamble, Editor-in-Chief, Becker's Healthcare

B. Key Issues for Academic Medical Centers
- Daniel DeBehnke, MD, Chief Executive Officer, Senior Associate Dean, Clinical Affairs, Medical College Physicians, Medical College of Wisconsin
- James Crawford, MD, PhD, FCAP, Professor and Chair, Pathology and Laboratory Medicine; Executive Director and Senior Vice President, Laboratory Services, Hofstra North Shore-LIJ School of Medicine, North Shore-Long Island Jewish Health System
- Airica Steed, EdD, RN, CSSMBB, FACHE, System Chief Customer Experience Officer, OhioHealth Corporate Office
- Moderated by Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Educator, Author, Managing Healthcare Reform: Ideas for Leaders

C. Impact of Respiratory Compromise in U.S. Healthcare
- Lee Fleisher, MD, Chair, Anesthesiology and Critical Care and Robert Dunning Dripps Professor, Anesthesiology and Critical Care, University of Pennslyvania, Perelman School of Medicine

D. Systems of Care: Strategies for Moving Pediatric Hospitals to a Systems of Care Approach Using Clinical Integration
- Robert Campbell, Senior Vice President, Business Development and Chief Strategy Officer, Phoenix Children's Hospital
- Chad Johnson, Senior Vice

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President and Executive Director, Phoenix Children's Care Network

E. Key Alignment and Capital Strategies
- Amy Crouch, CPA, Chief Executive Officer, Allied Physicians
- Lance Sewell, Chief Financial Officer, South Lake Hospital
- Mark Anderson, Chief Financial Officer, Lane Regional Medical Center
- Moderated by Paula Lovell, Founder, Lovell Communications, Inc.

F. Crafting and Managing Strategic Relationships: One Size Fits One
- Ann Huston, Chief Strategy Officer, Cleveland Clinic
- Josette Beran, Executive Director, Strategic Partnering and Network Integration, Cleveland Clinic

G. Data-Driven Strategies: How to Use the Information You Already Have
- Randy Davis, Vice President and Chief Information Officer, CGH Medical Center
- Mark Herzog, FACHE, President and Chief Executive Officer, Holy Family Memorial, Inc.
- Michael Hunt, DO, FACOP, Chief Medical Officer and Chief Medical Information Officer, St. Vincent's Health Partners, Inc.
- Moderated by Ayla Ellison, JD, Finance Editor, Becker's Healthcare

H. Why Can't We Be Friends? — an HR, Operations and Finance Collaboration for Labor Management
- Harry Reese, Jr., Chief Financial Officer, Ochsner Medical Center
- John Herman, Chief Operating Officer, Ochsner Medical Center
- Trudi Stafford, PhD, Chief Nursing Officer, Ochsner Medical Center
- Melissa Love, Senior Human Resources Business Partner, Ochsner Health System

2:30 - 3:10 pm

A. The Transformative New Executive Roles: Who are They and How do we Compensate Them?
- David Bjork, PhD, Senior Vice President and Senior Advisor, Integrated Healthcare Strategies
- Susan O'Hare, RN, CPNP, CPN, Senior Vice President, Integrated Healthcare Strategies
- Mark Laney, MD, President and Chief Executive Officer, Mosaic Life Care
- Anthony Bohn, System Vice President and Chief Human Resources Officer, Norton Healthcare

B. Buy-In: A Two Way Street
- Craig Saylor, FACHE, Chief Executive Officer, Somerset Hospital

C. Physician Satisfaction as a Way to Increase System Performance and Outcomes
- Katherine Bunting, PhD, Chief Executive Officer, Fairfield Memorial Hospital
- Mark Gridley, FACHE, Chief Operating Officer and Executive Vice President, Family Health Network
- Ricardo Martinez, MD, FACEP, Chief Medical Officer, North Highland
- Scott Nygaard, MD, Chief Medical Officer, Lee Memorial Health System
- Moderated by Molly Gamble, Editor-in-Chief, Becker's Healthcare

G. Health Imaging: Tools for Radiologists to Improve Interpretations, Quality and Outcomes
- Lincoln Berland, MD, Vice-Chairman, Patient Safety and Quality Improvement, UAB Medicine
- Karen Holzberger, Vice President and General Manager, Diagnostics, Nuance

H. Hospital Joint Venture Trends and Post-Transaction Compensation Considerations
- Colin McDermott, CFA, CPA/ABV, Director, VMG Health
- Alexandra Higgins, Manager, VMG Health

3:10 - 3:30 pm
Afternoon Break

3:30 - 4:10 pm

KEYNOTE
- Chris Van Gorder, FACHE, President and Chief Executive Officer, Scripps Health

4:15 - 5:00 pm

KEYNOTE PANEL — Politics, Strategy, Managed Care, Finance and More!
- Michael Dowling, President and Chief Executive Officer, North Shore-Long Island Jewish Health System
- Nancy Howell Agee, President and Chief Executive Officer, Carilion Clinic
- Barry Arbuckle, PhD, President and Chief Executive Officer, MemorialCare Health System
- Howard Dean, MD, Former Chairman, Democratic National Committee and Governor of Vermont
- Ken Kaufman, Chair, Kaufman Hall
- Moderated by Scott Becker, JD, CPA, Publisher, Becker's Healthcare; Partner, McGuireWoods LLP

5:00 - 7:00 pm
Cocktail Reception In Exhibit Hall

Friday, April 29, 2016

7:00 – 8:00 am
Registration and Continental Breakfast in the Lobby

8:00 – 8:35 am

KEYNOTE
- David Feinberg, MD, President and Chief Executive Officer, Geisinger Health System

8:40 – 9:15 am

KEYNOTE
- John Noseworthy, MD, President and Chief Executive Officer, Mayo Clinic

9:15 – 9:45 am
Doors Open for George W. Bush

10:00 – 11:00 am

KEYNOTE
- George W. Bush, 43rd President of the United States of America

11:00 - 11:20 am
Morning Break

11:20 – 12:00 pm

KEYNOTE
- Lloyd Dean, President and Chief Executive Officer, Dignity Health

12:05 - 12:45 pm

KEYNOTE PANEL — The Best Opportunities for Growth Today
- Steven Goldstein, President and Chief Executive Officer, Strong Memorial Hospital
- Randy Oostra, DM, FACHE, President and Chief Executive Officer, ProMedica
- Teri Fontenot, FACHE, President and Chief Executive Officer, Woman's Hospital
- Michael Rowan, FACHE, President, Health System Delivery and Chief Operating Officer, Catholic Health Initiatives
- Moderated by Barton Walker, JD, Partner, McGuireWoods LLP

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12:45 - 1:45 pm
Networking Luncheon

Concurrent Sessions:
Track A - CEO, Strategy and ACO Issues
Track B - ACOs, Population Health, Affiliation and Other Issues
Track C - Physician-Hospital Alignment
Track D - Patient Safety and Quality Issues
Track E - CFO and Financial Issues
Track F - Revenue Cycle Management Issues
Track G - Health Information Technology Issues
Track H - Thought Leaders

1:45 - 2:25 pm

A. Thriving as a Hospital in an Urban Environment
- José Sánchez, President and Chief Executive Officer, Norweigan American Hospital
- John Jay Shannon, MD, Chief Executive Officer, Cook County Health and Hospitals System
- Nancy Gaden, Chief Nursing Officer, Boston Medical Center
- Moderated by Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Educator, Author, Managing Healthcare Reform: Ideas for Leaders

B. Is the Era of the Traditional Health Insurer Dead?
- Brandon Edwards, Chief Executive Officer, ReviveHealth

D. Advanced Practice Providers: Strategies and Structures to Support High Quality, Lower-Cost Care
- Michelle Edwards, DNP, APRN, FNP, ACNP, National Vice President, Advanced Practice, Catholic Health Initiatives
- Dennis Absher Taylor, DNP, ACNP-BC, NEA-BC, Assistant Vice President, Center for Advanced Practice, Carolinas HealthCare System
- Julie Creaden, Senior Director Advanced Practice Nursing, Ann & Robert H. Lurie Children's Hospital of Chicago
- Moderated by Trish Anen, RN, NEA-BC, Executive Sponsor and Co-founder, The Center for Advancing Provider Practices; Vice President, Clinical Services, Metropolitan Chicago Healthcare Council

E. Lessons from the Experts: What's New, Next and Best in Healthcare Finance
- Donald Longpre, Chief Financial Officer, North Ottawa Community Health System
- Richard Franco, FHFMA, Vice President and Chief Financial Officer, Northwestern Medical Group
- Todd Hofheins, Executive Vice President and Chief Financial Officer, Providence Health & Services
- Karen Testman, RN, Chief Financial Officer, MemorialCare Health System
- Moderated by Rhoda Weiss, PhD, National Healthcare Consultant, Speaker, Educator, Author, Managing Healthcare Reform: Ideas for Leaders

F. Moving from Volume to Value
- Brad Bostic, Chairman and Chief Executive Officer, hc1.com

H. The Evolving, Strategic Role of Healthcare CXO
- Liz Boehm, Director, Vocera Experience Innovation Network

2:30 - 3:10 pm

A. Women's CEO Leadership Panel
- Ruth Brinkley, FACHE, President and Chief Executive Officer, KentuckyOne Health
- Sheri Milone, Chief Executive Officer, Lovelace Women's Hospital
- Nancy Vish, RN, PhD, NEA-BC, FACHE, Chief Executive Officer, Baylor Heart and Vascular Hospital
- Barbara Martin, FACHE, Chief Executive Officer, Vista Health System
- Moderated by Paula Lovell, Founder, Lovell Communications, Inc.

B. Merger Reflections: Lessons Learned and Practical Advice
- Chris Lumsden, President, Sentara Halifax Regional Hospital
- Kevin Vermeer, Chief Executive Officer, UnityPoint Health
- Philip Newbold, Chief Executive Officer, Beacon Health System
- Moderated by David Gordon, Principal, Juniper Advisory

C. Improving Clinical Results via Closed-Loop Performance Management to Rise to Top 10 Percent Nationally in Care Metrics
- Joseph Scott, FACHE, President and Chief Executive Officer, Jersey City Medical Center/Barnabas Health

D. Can Your Hospital Survive? Clinical Cost Containment for Hospital Administrators and Medical Leadership
- Ian Newmark, MD, Chief, Critical Care Medicine; Assistant Clinical Professor, Medicine, North Shore University Hospital at Plainview, Hofstra-North Shore LIJ School of Medicine

E. Benchmarking and Assessing the Financial Strength of a Hospital
- Anthony Creed, Chief Financial Officer, VA Southern Nevada Healthcare
- Darryl Linnington, Chief Financial Officer, McAlester Regional Health Center
- Melissa Whitmer, Senior Vice President, Healthcare, KeyBank
- Moderated by Molly Gamble, Editor-in-Chief, Becker's Healthcare

F. Improving Patient Access in a Get-It-Now, Digital World: A Case Study
- TBD

G. Mobile Health: New Developments
- Pamela Banchy, Chief Information Officer, Summa Western Reserve Hospital
- Steve Hess, Chief Information Officer, University of Colorado Health
- Moderated by Ayla Ellison, JD, Finance Editor, Becker's Healthcare

H. Competition for Care in a Rural Community
- Duke Anderson, President and Chief Executive Officer, Hillsdale Community Health Center
- Jeff Hill, Regional Vice President, Quorum Health Resources
- Gayle Trupiano, Vice President, Performance Excellence, Ascension Health
- Moderated by Amber Walsh, Partner and Healthcare Department Chair, McGuireWoods LLP

3:10 - 3:30 pm
Networking Break in the Lobby

3:30 - 4:10 pm

A. Leadership and Emotional Intelligence: Why This Does Make a Difference
- Shelly Hunter, FHFMA, Chief Financial Officer, Mercy SW Missouri-Kansas
- Lynn Ricci, FACHE, Senior Vice President and Chief Operating Officer, Hospital for Special Care
- Leslie Marsh, RN, Chief Executive Officer, Lexington Regional Health Center
- Tim Weir, Chief Executive Officer,

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Olmsted Medical Center
- Moderated by Amber Walsh, Partner and Healthcare Department Chair, McGuireWoods LLP

B. Hospitals: Survival of the Adaptable
- Brian Sanderson, Managing Principal, Healthcare Services, Crowe Horwath LLP
- Bryan Becker, MD, Vice President, Clinical Integration and Associate Dean, Clinical Affairs, University of Chicago Medicine

C. The Role of Hospital-Based Services in a Value-Based Purchasing World
- Mike Snow, President and Chief Exectuive Officer, TeamHealth

D. Lowering the Cost of Care with Skilled Nursing Facilities
- Scott Polenz, CPA, District Administrator, Marshfield Clinic Health System

E. Compliance
- Ken West, FACHE, Chief Operating Officer, Ethics and Compliance Officer, Medical Center of Trinity
- Fahad Ahmed, Manager, Deloitte Advisory
- Joseph Anton, RN, Vice President, Clinical and Support Services, Thomas Jefferson University Hospitals
- Debi Hinson, CHC, CHP, CCEP, CHRC, Chief Research and Associate Compliance Officer, Columbus Regional Health
- Moderated by Holly Carnell, JD, Associate, McGuireWoods LLP

F. Enhancing Revenue Cycle Processes to Improve Claims and Boost Operational Efficiency
- Katherine "Kittie" Smith, Director, Revenue Cycle, Baptist Health Medical Group, Inc.
- Allison Case, Client Manager, ZirMed

H. Ten Lessons from the First Full Year at Risk in BPCI
- Jonathan Pearce, CPA, FHFMA, Principal, Singletrack Analytics, LLC
- Kelly Price, Senior Director, DataGen, A HANYS Solutions Company

4:15 - 4:55 pm

B. Employee-Based Population Health Management: A Step Toward Accountable Care
- Richard Boehler, MD, FACPE, President and Chief Executive Officer, St. Joseph Hospital, Covenant Health

C. Process and Performance Improvement in Mid-Size Rural Hospitals
- Craig Luzinski, PhD, Vice President, Performance Optimization, Cheyenne Regional Medical Center
- Phyllis Sherard, PhD, Chief Strategy Officer and Vice President, Population Health, Cheyenne Regional Medical Center
- Judit Olah, PhD, Director, Strategic Performance Analytics, Cheyenne Regional Medical Center

D. Life-Saving Data: How Integrating Real-Time Surveillance and Analytics in Clinical Systems Reduced Sepsis Mortality at Huntsville Hospital
- Joycelyn Craighead, RN, CPHQ, Director, Quality, Huntsville Hospital
- Stephen Claypool, MD, Medical Director and Vice President, Clinical Development and Informatics, Wolters Kluwer

E. Navigating the Changing Dynamics of the Intergenerational Workforce: Staffing Strategies for the Highly Productive Health Care Organization
- Jean Ann Larson, FACHE, FHIMSS, DSHS, President and Founder, Jean Ann Larson & Associates
- Santosh Mohan, CPHI Clinical Transformation Fellow, Office of the Chief Information Officer, Stanford Health

F. The Role of the Center of Excellence in a Value-Based World
- Joseph Nicholson III, DO, Corporate Senior Vice President and National Medical Director, Payer and Employer Relations, Cancer Treatment Centers of America
- Scott Pickens, Managing Director, Arlington Healthcare Group
- Jamie Solak, Managing Director, Arlington Healthcare Group

5:00 - 6:00 pm
Cocktail Reception in Exhibit Hall

Saturday, April 30, 2016

7:00 - 8:00 am
Continental Breakfast in the Lobby

Concurrent Sessions:
Track A - CEO, Strategy and ACO Issues
Track B - ACOs, Population Health, Affiliation and Other Issues
Track C - Physician-Hospital Alignment
Track D - Patient Safety and Quality Issues
Track E - CFO and Financial Issues
Track F - Revenue Cycle Management Issues
Track G - Health Information Technology Issues
Track H - Thought Leaders

8:00 - 8:40 am

KEYNOTE
- Quint Studer, Founder, Studer Group

8:45 - 9:25 am

A. Slowing the Acute Care Merry-Go-Round
- Mark Herzog, FACHE, President and Chief Executive Officer, Holy Family Memorial, Inc.

B. Game of Thrones: Leading Your Team to the Top
- Jan Kleinhesselink, RN, CPHQ, Chief Quality Officer, Lincoln Surgical Hospital
- Carmen Lester, RN, JD, CPHRM, Chief Clinical Officer, Lincoln Surgical Hospital

C. Neighborhood Partnerships to Improve the Health of Communities
- Jennifer Snow, Director, Accountable Communities, Greenville Health System

D. Clinical and Financial Successes at Advocate Health Care Utilizing our Tele-ICU Program
- Michael Ries, MD, FCCM, FCCP, FACP, Medical Director, Critical Care and eICU, Advocate Health Care, Kensington Support Center
- Cindy Welsh, RN, Vice President, Critical Care and Medical Professional Affairs, Advocate Health Care, Kensington Support Center

E. OR Optimization: Right Sizing to the Future
- Fred McQueary, MD, President, Ambulatory Care and Chief Clinical Officer, Mercy
- Vance Moore, Senior Vice President, Operations, Mercy
- Betty Jo Rocchio, CRNA, Vice President, Perioperative Performance Acceleration, Mercy

F. What We Did in the Past Won't Get Us There! Care Management and Revenue Cycle Redesign
- Cynthia Spradlin, RN, Specialist Leader, Strategy and Operations – Healthcare Provider, Deloitte

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- Jeanine M. Tome, RN-BC, ACM, CPHQ, Vice President, Care Continuum, Saint Vincent Hospital, Allegheny Health Network
- Heather Cote, RN, Specialist Master, Strategy and Operations – Healthcare Provider, Deloitte Consulting
- Debbie Hoffman, RN, Specialist Master, Strategy and Operations – Healthcare Provider, Deloitte Consulting
- Len Mandel, Specialist Master, Strategy and Operations – Healthcare Revenue Cycle, Deloitte Consulting

G. Wired to Save Lives: A Unique Virtual Hospital Experience
- Donald Kosiak, Jr., MD, FACEP, CPE, Medical Director, Avera eCare

H. Unified Communication Strategy Improves Patient Experience and Outcomes
- Sunitha Sastry, Director, Experience Improvement and Innovation, Patient Experience and Engagement Program, The University of Chicago Medicine
- Susan Murphy, RN, Executive Director, Patient Experience and Engagement Program, The University of Chicago Medicine

9:25 - 9:45 am
Morning Break

9:45 - 10:25 am

A. A Leading CEO and his Millennial Leading Daughter: What Leaders Should Know About Millennials and Vice Versa
- Amelie Karam, Millennial Specialist
- Christopher Karam, President and Chief Executive Officer, CHRISTUS St. Michael Health System; Chief Experience Officer, CHRISTUS Health

B. Academic-Community Integration
- Robert Colvin, FACHE, Principal, Health System Advisors
- Charlie Powell, President, Physician Enterprise, KentuckyOne Health

D. An Innovative Approach to Disease Management and Wellness: Bridging from Fee for Service to Population Health Management
- Gary Maras, Chief Executive Officer, UPMC Hamot Heart and Vascular Institute, University of Pittsburgh Medical Center

E. Building a Growth Engine for the New Retail Market: Successfully Integrating Academic and Community Physicians in a Regional Accountable Care Organization
- David Fairchild, MD, Director, BDC Advisors; Professor, University of Massachusetts Medical School
- Lynn Stofer, President, Partners Community Physician Organization, (Formerly known as PCHI)

G. The "Breached" Whale: Avoid Security Risks with Sound Data Defense Strategies
- Ned Campbell, Executive Vice President, Quality and Compliance, Zotec Partners

H. Utilizing Quality Management System (QMS) Audits to Improve Process Reliability and Efficiency
- Donna Willeumier, MT (ASCP), CPHQ, Administrator, Quality Management and Regulatory, Advocate Health Care

10:30 - 11:10 am

A. Using General Business Excellence Tactics to Raise the Profile of Medical Informatics Projects
- Anupam Goel, MD, Vice President, Clinical Information, Advocate Health Care

B. Medical Home to Medical Neighborhood to Connected Healthcare Community: Collaboration Yielding Big Data; Real Benefits in Colorado
- Mark Crockett, MD, Chief Executive Officer, Rise Health
- Patrick Gordon, Associate Vice President, Rocky Mountain Health Plans

D. We Are Safe: How to Reduce Incidences of Serious Harm Across the Enterprise
- Jacklynn Lesniak, RN, Chief Nursing Officer, Cancer Treatment Center of America at Midwestern
- Nancy Hesse, RN, Chief Nursing Executive, Cancer Treatment Centers of America

E. Design and Implementation of a Strategic Approach to High Reliability Healthcare
- Kate Kovich, OT, CPPS, Vice President, Patient Safety, Advocate Health Care

G. Bridging the Gap Between Clinical and Technology: Preparing Your Organization for Success
- Gregory Ator, MD, Chief Medical Informatics Officer, University of Kansas Health System
- Neil Treister, MD, FACC, Medical Informatics Officer and Caridologist, Sharp Community Medical Group
- A. Peter Catinella, MD, Medical Informaticist, Banner-University Medicine
- Moderated by Don Michaels, PhD, Senior Vice President, Hayes Management Consulting

H. Threading the Value-Based Needle: Managing Reputation in the Era of Publicly-Reported Quality Measures
- Shannon Sims, MD, PhD, Vice President and Chief Analytics Officer, Froedtert & The Medical College of Wisconsin
- Tom S. Lee, PhD, Founder and Chief Executive Officer, SA Ignite

11:15 - 12:00 pm

A. Service Line Strategy and Data
- Nancy Vish, RN, PhD, NEA-BC, FACHE, Chief Executive Officer, Baylor Heart and Vascular Hospital

B. Risk Management in the Project Portfolio
- Mike Canfield, Vice President and Chief Information Officer, Augusta Health

C. Managing Complexity: How Community Hospital CEOs are Building Competitive, Innovative Organizations for the Future
- Carol Geffner, PhD, President, Newpoint Healthcare Advisors, LLC
- Darlene Stromstad, Chief Executive Officer, Greater Waterbury Health Network
- Ginger Williams, MD, FACEP, FACHE, President and Chief Executive Officer, Oaklawn Hospital

F. Denials Management: Reducing and Eliminating Claim Denials Utilizing Best Practices
- Rochelle Dahmen, Revenue Cycle Manager, Eide Bailly LLP

G. Using IT to Improve Doctor Happiness
- Lyle Berkowitz, MD, FACP, FHIMSS, Associate Chief Medical Officer, Innovation, Northwestern Medicine

Meeting Adjourns

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Nursing Rated Most Honest, Ethical Profession Once Again

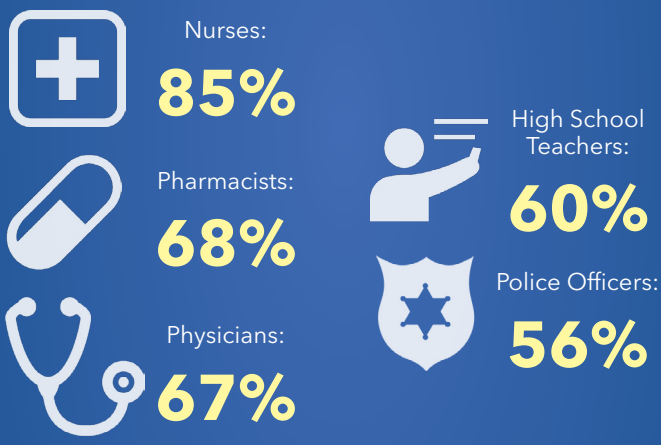
By Tamara Rosin

Nursing is the most trusted profession, according to Gallup's annual poll ranking honesty and ethics in various fields.

The public has consistently named nursing as the most honest and ethical profession in the U.S. for the last 14 consecutive years. In 2015, 85 percent of Americans said nurses' honesty and ethical standards are "very high" or "high," setting them 17 percentage points above the next highest-rated profession, pharmacists.

Here is a look at the five most and least ethical professions, as rated in Gallup's poll. The percentages reflect those who ranked a professions' ethics as "very high" and "high."

Highest



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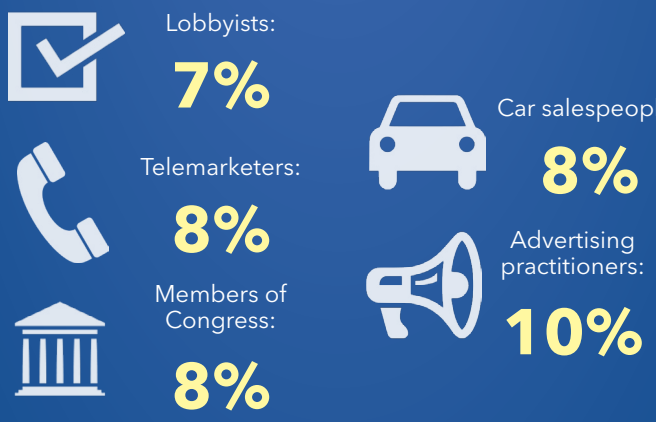

Medicare Cuts Payments to 758 Hospitals for HACs: 6 Things to Know

By Ayla Ellison

In fiscal year 2016, 758 hospitals will have their Medicare payments reduced for being among those with the highest rates of hospital-acquired conditions.

Here are six things to know about the HAC Reduction Program and the hospitals receiving penalties.

1. Created under the Affordable Care Act, the HAC Reduction Program is aimed at preventing harm to patients.

2. In FY 2016, 758 out of 3,308 hospitals subject to the HAC Reduction Program are in the worst performing quartile. These facilities will have their Medicare payments reduced by 1 percent for all discharges occurring between Oct. 1, 2015, and Sept. 30, 2016.

3. CMS said 54 percent of the hospitals that were in the worst performing quartile in FY 2016 were also in that quartile in FY 2015.

4. The FY 2016 penalties will total approximately $364 million, according to CMS.

5 There are two domains used to score hospitals in FY 2016. The first domain includes the Patient Safety Indicator 90 Composite and is weighted at 25 percent. The second domain is weighted at 75 percent and includes three measures: central line-associated bloodstream infections, catheter-associated urinary tract infections and surgical site infections.

6. Hospitals are classified based on their measure results, with each hospital assigned a score between one and 10 for each measure. In FY 2016, hospitals with a total HAC score greater than 6.75 are subject to a payment reduction. ■

10 Things to Know About Kaiser Permanente School of Medicine

By Erin Marshall

Healthcare giant Kaiser Permanente will open a medical school in fall 2019, a strategic move CEO Bernard Tyson calls a "natural evolution."

Although the development process is in early stages, the Oakland, Calif.-based nonprofit health system has already outlined a few major details and philosophies behind the plan.

Here are 10 things to know about the health system and its Kaiser Permanente School of Medicine.

1. A few major logistics about the medical school have been released. The medical school will open in the fall of 2019 with a class of 48 students, according to *The Wall Street Journal*. Kaiser said tuition will be comparable to and competitive with other medical schools, according to the *Los Angeles Times*.

2. At the time of publication, other details have not been negotiated. Kaiser Permanente has not said how much the school will cost. Although the school will be somewhere in Southern California, Kaiser is still determining a final location for the school, as well as the campus size.

3. Leadership for the school is yet to be determined. One of the medical school's top priorities for 2016 is to recruit a dean. However, some leaders have already announced their involvement in the school. Christine Cassel, MD, president and CEO of the National Quality Forum, will leave her post March 1 to join the leadership team designing the medical school.

4. A nonprofit health system planning a medical school is rare. The majority of the medical schools in the United States are affiliated with universities rather than health systems. "There are precedents, but this will be different," said John Prescott, MD, chief academic officer for the American Association of Medical Colleges. "It's an integrated healthcare system that's looking at developing a medical school. I think there will be some surprises as the school unfolds."

5. Kaiser CEO Bernard Tyson spoke out about the endeavor to build the school. "This is a natural evolution for us," he said. "We are very motivated in being part of the transformation of the entire healthcare ecosystem."

6. Kaiser already works with medical school students. Currently, 600 physicians are finishing their residency programs at Kaiser Permanente. Annually, thousands of others complete part of their medical training at Kaiser.

7. The school will capitalize off Kaiser's existing diversity efforts. The Kaiser Permanente School of

Do Physicians Drink Too Much Coffee?

By Max Green

By their own admission, physicians and nurses drink more coffee than engineers, teachers, scientists, machine operators and government workers.

Nearly half of Americans admit to feeling less productive without coffee, and existing literature indicates clinicians aren't drinking coffee for the taste, but for its stimulant properties. Some hospitals around the world, such as Queensland Health in Australia, suggest staff use coffee as a tool to stay alert on the job. Queensland even suggests a recommended dosage: 400 mg per day – equivalent to about six cups of coffee. But are most healthcare workers drinking that much?

Researchers attempted to answer this question by looking at one full year's worth of purchasing habits at a large teaching hospital in Switzerland. They analyzed the coffee purchasing habits of 766 medical professionals and found 84 percent of them purchased coffee in a hospital cafeteria at least one time in 2014. Over the year, they consumed 70,772 cups total. The study, aptly titled "Black Medicine," is published in the *British Medical Journal*.

Orthopedic surgeons drank the most coffee, followed by radiologists, general surgeons, neurosurgeons, neurologists, internists, gynecologists and anesthetists, according to the paper. Other findings included men drink more coffee than women and older clinicians were more likely to consume more than younger clinicians. The study also looked at generosity when it came to purchasing coffee and found older coffee buyers were more likely to buy a round for their colleagues.

The paper notes the health effects of coffee are up for debate, and the results may not be applicable to all institutions and countries. According to 2014 data, the U.S. comes in at No. 16 on a list of nations that consume the most coffee, and Switzerland comes in at No. 14, only two notches apart. ■

Medicine hopes to recruit more minority students "to better reflect the communities we serve," according to Edward Ellison, MD, executive medical director of Southern California Permanente Medical Group. "We anticipate them going out into the communities and spending time with patients in the communities from which they come," he added.

8. Like other medical schools across the nation, the Kaiser Permanente School of Medicine will strive to change traditional medical education. In addition to focusing on research, Kaiser's medical school will include more real-world, hands-on experience for students. This effort, which is being adopted by medical schools throughout the nation, will be built around two years of science followed by two years of clinical work. "The physician will not be sitting in a lecture hall like I did," said Dr. Ellison. "It's taking a different approach, turning the model almost upside down."

9. The decision has been met with some skepticism. Establishing a medical school is "fraught with risk" and could be a "huge waste of money" if the school turns into a specialty-focused academic medical center, according to John Deane, president of Advisory Board Consulting and Management. "On the other hand, they have an opportunity to do this in a new and different way that could be a form of disruptive innovation that could become a new standard for teaching doctors."

10. Kaiser Permanente by the numbers. Kaiser — whose annual revenue last year was $56.4 billion — has approximately 10.2 million members, 80 percent of whom are in California. The nonprofit health system runs 38 hospitals, owns hundreds of clinics and has almost 18,000 physicians on salary. It operates in eight states and the District of Columbia. ■

Michigan Health System Fires 68 CRNAs Over Outsourcing Dispute

By Tamara Rosin

Warren, Mich.-based St. John Providence Health System has terminated the contracts of 68 nurse anesthetists at two of its hospitals after they repeatedly rejected terms offered under a new outside contractor, according to the *Detroit Free Press*.

The hospitals – Providence Park Hospital in Novi, Mich., and Providence Park Hospital in Southfield, Mich., – are now staffed with anesthesiologists brought by the new contractor. The contractor is called PSJ Anesthesia, a newly founded company affiliated with Dominick Lago, MD, an anesthesiologist at both hospitals.

The health system said it will remain with its decision to outsource the nurses, despite previous warnings by the nurses they would stage a walk out tonight at midnight. The 68 nonunionized nurses repeatedly rejected the terms for new contracts under PSJ Anesthesia for reasons unrelated to pay, attorney David Shea, who is representing the nurses, told the *Detroit Free Press*.

The new contracts offered the nurses similar pay but different work rules and regulations around scheduling, as well as what the nurses considered insufficient disclosure on other policies and procedures, according to the report. They also had a problem with working under Dr. Lago and his new company.

"They would rather lose their jobs than work for PSJ," Mr. Shea said, according to the report. "And now the question for Providence is, 'What is more important for them, PSJ or their nurses?'"

St. John Providence issued a statement saying it plans to continue to transition its nurse anesthesia services at both hospitals to PSJ Anesthesia. ■

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Data Where You Might Not Expect: Johns Hopkins Medicine Goes Performance-Transparent With Dashboards

By Max Green

Hospitals are constantly having their data collected, combed through and compared. Whether in quality and safety databases or financial rankings and credit ratings, third parties like *U.S News & World Report* and federal organizations like CMS are watching to see how health systems stack up against one another.

Some hospitals are taking data collection into their own hands, getting a better perspective and diving deeper to drive improvements. Two years ago, Baltimore-based Johns Hopkins Medicine decided to paint a more informed picture of the performance of its five hospitals by rolling out a dashboard that collects data on a number of quality and safety metrics within the system, organizing it in one place.

Making quality data available to staff

To drive improvements in patient outcomes and employee performance at the micro level, for individuals and their units, the database gathers information and metrics pertaining to hospital-acquired infections, core measures from CMS and The Joint Commission, HCAHPS results, hand hygiene performance and measures of patient experience, among others. Johns Hopkins' 41,000 employees can visit the dashboard to view their individual performance numbers, as well as overall hospital ratings.

"I think an area where we've really benefited from the dashboard is around HCAHPS," says Matt Austin, PhD, professor of anesthesiology and critical care medicine at Johns Hopkins' Armstrong Institute for Patient Safety and Quality. "We've had a large, systemwide focus on HCAHPS in the last 12 to 18 months, and the ability to easily share unit-level information across a large enterprise has really been helpful in both having everyone understand where we are and improving performance."

The goal of the internal dashboard is to share key quality and safety measures with the aim of being able to look at data all the way down to unit-level performance, Dr. Austin says.

"We feel like real change happens at an individual unit level, so where we can share that data, our experience has been that's what will drive the greatest improvements."

Going public with performance data

More recently, the health system implemented an external-facing dashboard, including much of the same information, which is accessible to patients and anyone curious about Johns Hopkins Medicine's performance.

The health system has four major goals in making performance data visible to the public. The first is to hold itself accountable to patients, their families and the communities it serves. If the hospital makes claims about its performance measures and how they stack up against competitors, what better way to reassure patients those claims are true than by displaying the numbers?

Second, the dashboard consolidates all of the disparate data about Johns Hopkins into one place — when patients seek information about a hospital or health system online, they are inundated with reviews, numbers and measures of performance that may not be from credible sources. Patients might also be hunting for a specific measure of performance and having a hard time finding it. The dashboard is a one-stop shop for all of the data that is available.

Third, there is a market demand for this type of transparency and information consolidation. Not only did Johns Hopkins see its competitors undertaking similar initiatives, but patients also indicated that a tool like this would be very helpful to them, and the system wanted to engineer a way to collect all the safety and quality data that might help them make better informed decisions about care in one place.

Lastly, taking full ownership of all of its measures and organizing them in one place enables Johns Hopkins to create a narrative around the data.

"It allows us to talk directly to our patients about why the data are important and what we're continuing to do to improve our performance in each of the areas," Dr. Austin says.

Unintended benefits of sharing performance data

Beyond giving patients a direct line to important hospital data, the dashboards allow Johns Hopkins officials to track performance on whatever measures they see fit in one place. If there's a particular area that CMS doesn't require the system to report on, Johns Hopkins still has a platform to gather information and improve on that data point.

"It's a feedback loop, it's understanding where performance is, being able to understand when interventions are put into place and seeing how performance changes over time," he says. "One of the pieces of feedback we've gotten from employees of Johns Hopkins Medicine is they are really interested in being able to compare their unit's performance to another unit's performance, and we're working on a functionality to would allow for that."

In that sense, Dr. Austin says the decision to go live with the internal dashboard has given hospital staff more of a voice about the tools they'd like to have at their disposal and the steps administration can take to help them improve. It has also encouraged a healthy sense of competition and spurred cultural change.

"One of the things we have seen is a greater awareness of performance and how we're doing in quality and safety. We've been creating a culture of data where people are comfortable talking about data and making decisions about data," he says. "That's a big cultural change for us." ■

Dr. Nick van Terheyden: EHRs are Like Junk Drawers – But There's a Way to Declutter Them

By Nick van Terheyden, MD, CMO, Dell Healthcare & Life Sciences

Searching for patient data in an EHR is rather like rummaging in that catch-all drawer most people have in their kitchen. You know the one — it's where everything goes that doesn't have a designated place or somehow doesn't get put where it belongs. That drawer has many useful items in it. All those jumbled bits and pieces may be useful someday, but you don't need them right now.

An EHR is a lot like that drawer. It has plenty of useful data in it, and a lot of other bits and pieces that, with the right integration tools and the right analytics, will be useful someday. The problem is that right now you need a specific piece of patient data, and to find it you end up rummaging through a lot stuff that isn't of any help at the moment.

Worse yet, the data you need can be a test result that is locked up in another system. It's like knowing that you have a small screwdriver that is perfect for the task at hand, but you loaned it to your neighbor. You could go knock on the door and ask for it, but they might take forever to answer the door, and then they'd have to rummage through their catch-all drawer to find it, and you just don't have time to mess with it. So you buy a new one.

Like that screwdriver, the data you need is often locked up in another nearby system, and you could get it if you asked for it, but you don't have time to knock on the digital door and wait around for the other system to find it and send it to you. So you order a new test.

A better way to rummage in the digital data drawer

To take the analogy a bit further, imagine that you hire an organizational assistant to sort all the stuff in the catch-all drawer, pull out the bits that are currently useful and place them on a shelf, neatly organized and easy to find. And the assistant sets up a network with your neighbors that tells you exactly where all their useful bits are, and places those useful bits in a place you can access easily. And then he sets ups a drone system to bring those useful bits to you whenever you needed them.

That would be pretty amazing, don't you think?

It is possible to create a digital organizational assistant to rummage through the EHR and present you with the data you need just when you need it. There are several developers working on new interfaces for EHRs, which would treat the EHR like a relational database rather than a clinical user interface.

The new interface would gather data from the EHR and send data back to it, but would present the physician or other caregiver with an interface specifically designed for that clinician and his view of patient care. Currently, EHRs are gathering all sorts of data that is useful for billing, analytics, population health risk stratification and other purposes. But often that data isn't useful for real-time patient interactions, and the interfaces are less than ideal.

It's no secret that physician dissatisfaction with EHRs is high (there's even a rap song about it). [Editor's note: See "New Music Video Puts EHR Woes to the Tune of Jay-Z," on *beckershospitalreview.com*.]But with billions invested in existing applications, it's unlikely that hospitals, health systems and physician practices are going to make a major change any time soon. And EHR vendors don't have any real incentive to do the kind of overhaul of their applications that physicians really want.

This "digital assistant" approach will eliminate much of the frustration of dealing with EHRs, while making good use of the existing investments. And if the right integration tools were incorporated into this interface, it could conceivably rummage through other EHRs, pharmacy systems, emergency department systems and other clinical applications in real time to find all the useful data and present them to you in a way that is relevant to the patient and the clinical decision-making process.

> **"The data you need is often locked up in another nearby system, and you could get if you asked for it, but you don't have time to knock on the digital door and wait around."**

Here's an example of how that would work.

Let's say you are a primary care physician and you have a diabetic patient, Mrs. Johnson, who goes to the ED on the weekend because of a fall. If your digital assistant sorted through the EHR systems of all local EDs daily and pulled information about your patients into your system, you would know that Mrs. Johnson had an incident that could be related to poor blood sugar control. Did she fall due to dizziness or faintness? Is she having issues with her arthritis? Is she developing a heart condition?

If your digital assistant also pulled in Mrs. Johnson's blood

glucose readings, you could review the information quickly. That would give you the chance to adjust her medications, if need be, and coach her on ways to keep her glucose in tighter control. Or perhaps you'd have the chance to confirm that the diabetes was actually under good control, and do a proactive review to address other issues that may put her at risk for a major medical event.

If your digital assistant routinely pulled in pharmacy information, you could see if Mrs. Johnson was filling her prescriptions on schedule. If she isn't, you could find out why and help her solve the problem. A study published in 2014 in the *Annals of Internal Medicine* found that nearly a third of all new prescriptions weren't filled within nine months; a survey by the group Prescriptions for a Health America (a coalition of physicians, patients and pharmacy and healthcare industry groups) found that approximately 60 percent of patients don't take medications as they are prescribed. The group also found that better medication adherence resulted in significant reductions to other medical costs.

And how about co-morbidities that result in visits to specialists? You could be alerted if Mrs. Johnson fills a prescription from a cardiologist or rheumatologist or an orthopedist or any other physician. That's important information, because you want to be sure that any new medications won't interact negatively with the medications she is already taking. And you want to know if she has other health problems that she might not have mentioned to you. If those other physicians also had a digital assistant that mined the pharmacy system, they'd be alerted to what medications you are prescribing. That would help all of Mrs. Johnson's caregivers provide higher quality medical services, and possibly provide Mrs. Johnson with a better quality of life at a lower cost overall. It would also offer her an opportunity to see, use and share her own medical record and information with her care team and family.

A new standard for data will help

To make all this rummaging in the data easier and more accurate, HL7, the international group working on interoperability issues, has a new standard and application programming interface called Fast Healthcare Interoperability Resources, also known as FHIR (pronounced like fire). This new standard is just beginning to be used, and one of its goals is "to facilitate interoperation between legacy healthcare systems, to make it easy to provide healthcare information to healthcare providers and individuals on a wide variety of devices from computers to tablets to cell phones, and to allow third-party application developers to provide medical applications which can be easily integrated into existing systems."

FHIR should greatly advance development of the kind of interfaces we need to make EHRs easier to use and more clinically useful. Physicians can aid that advancement by insisting that any new applications or tools adopted are based on these standards.

If vendors get on board and use these standards, we'll see a revolution in how physicians, nurses and other caregivers interact with EHRs. The good news: Vendors seem to like the new standards, and they are quickly moving to use them.

Nick van Terheyden, MD, is CMO of Dell Healthcare & Life Sciences. He previously served as CMIO of Nuance Communications. Dr. van Terheyden is a 25-year veteran of healthcare technology. He aided in the development of one of the first EMRs and served as a business leader in one of the first speech recognition Internet companies. He is a graduate of the Royal Free Hospital School of Medicine, University of London and has several professional memberships including HIMSS, mHealth Executive Committee, AMIA and AMDIS. ■

Why Interoperability Still Eludes Healthcare: Q&A With Dr. Charles Jaffe CEO of HL7

By Max Green

Health Level Seven International has been fighting the good fight for interoperability since it was founded in 1987. The group has created, defined and spearheaded initiatives to enable the widespread adoption of interoperable standards. HL7's latest standard, Fast Healthcare Interoperability Resources, or FHIR, is being tested and implemented in healthcare settings worldwide for facilitating electronic information exchange. But HL7's focus on interoperability goes beyond healthcare, and the standards the group works to develop are applicable to federal agencies such as the Food and Drug Administration and the Department of Veterans Affairs, among others around the world.

Charles Jaffe, MD, PhD, CEO of HL7, took time to speak with *Becker's Hospital Review* about HL7's standards, how vendors fit into the picture and why we still don't have seamless interoperability.

Q: How do you explain HL7 and its goals when you're doing outreach for the organization?

Dr. Charles Jaffe: HL7 is thousands of volunteers all over the world – we're in more than 40 countries whereby statute or de facto. We are the standards by which healthcare information is exchanged on a multitude of platforms for different reasons. That includes patient care – in the United States for

example, our work with CMS helps provide data on billing and quality measures. In most countries there are enormous initiatives around public health where we provide the standards for a host of public health problems, from consolidating quality data to immunization records and other registries.

We also support national requirements in different countries that are unique to those countries. In the United States, that refers to meaningful use, and other countries have taken some of the meaningful use requirements from the United States and leveraged the exact same standards we've developed here to not only simplify their national agenda, but ensure interoperability of healthcare providers across national borders.

Q: HL7 is often associated with increasing interoperability but is a very multi-faceted organization. How important is interoperability in the big picture?

CJ: I think interoperability is the key. There are many different definitions of interoperability, though – semantic interoperability, which the technophiles like to throw around, or business interoperability, workflow, utilization and so forth. The fact is we need to have data exchange among entities, so we're not limiting the kinds of data that simply support one patient being cared for by one clinician. In today's world we have a multitude of stakeholders in the continuum of healthcare delivery and wellness.

In the inpatient paradigm it's fairly simple, but the continuity of care and the types of individuals who interact with patients, loved ones and consumers to support people is growing, and they need that data to make decisions. Even more importantly, as we move toward a new vision of patient care and wellness, the data needs to be in a form that validates the efficacy and cost of intervention, whether it's medications or procedures or studies.

Q: Does the technology exist today to make healthcare completely interoperable?

CJ: No, it doesn't exist now. And some of the obstacles relate to the way a multitude of standards evolve, the requirements for customization or localization and the technical barriers associated with it. I believe policy supervenes technology. We've heard a lot in the last year about interoperability blocking. That's a serious misconception.

There's often very little business case to develop solutions for interoperability or even health information exchange – end users, such as health systems, aren't keen on sharing data and clinicians and providers misinterpret HIPAA requirements. The benefactor is often the patient and there's no way to sustain a business model with the patient at the center of the system. There are a number of competing platforms and philosophies that aim to achieve this, but to date none of them have become as important as the payment system needs. Until the policy changes, that's not going to happen very quickly.

Q: One of the challenges surrounding interoperability is figuring out how to incentivize stakeholders to participate, how do you view this issue?

CJ: The ultimate question is interoperable for whom? If you have a business case to share data between the lab, the electronic order entry, the billing entity, patient care providers and tax systems, it is one level of requirement. But to share it outside of your entity requires either a unified system or one-off mapping of resource to resource. For example, simply designating gender, male-female, mf, 0-1, can be a hurdle if two systems can't agree. Then you need an interface to map the two.

Then it gets far more complex when you have patient identification at the heart of this. For example, in Southern California there are 10,000 people named Maria Gonzalez. Kaiser Permanente does its very best to issue them unique patient identifiers, but it's still a challenge. I've been told by the folks in Utah they have very similar naming problems. Until we embrace the notion of a unique patient identifier, we're going to have interoperability problems sharing patient data between systems.

Our matching algorithm, while very good, doesn't achieve 100 percent accuracy. All you have to do is look at your own credit report. There are likely at least dozens of people with your name. Not only does their information make it into your credit report, but matching algorithms pull in data from people you might share just a first name or last name with. How did the matching algorithms based on Social Security number get so inaccurate? I don't know the answer to that, but until we have a unified system for the United States population, we'll still have interoperability problems.

Q: What is HL7's relationship like with the larger EHR vendors in the United States?

CJ: We've always had excellent relations with the EHR vendors, but FHIR has driven a level of cooperation and collaboration that frankly we've never seen. When I announced The Argnoaut Project in December 2014, most of the press was focused on the fact Epic and Cerner were at the table together, not that there was this unique project about accelerating interoperability. Today we have ongoing Argonaut projects around fast development and fast identification of problems.

All of these require weekly conference calls among the big vendors in the United States, and they collaborate at a level not before seen in terms of developing FHIR-based solutions in terms of security, authentication and data identification. These partnerships are remarkably open and collaborative; I can't speak more highly about the new level of cooperation that The Argonaut Project has fostered. ■

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Retiring Memorial Healthcare CEO Frank Sacco Shares Advice From His 42-Year Career

By Emily Rappleye

Feb. 29 is a significant day at Hollywood, Fla.-based Memorial Healthcare System. It marks the last day of Frank Sacco's tenure as president and CEO of MHS, a 28-year stretch of marked growth for what is now one of the largest public health systems by revenue in the country.

Mr. Sacco joined MHS in 1974, after serving in the Army Medical Service Corps. He earned a master's degree in healthcare management from Miami-based Florida International University and worked his way up through several management and administrative positions. When Mr. Sacco took the helm as CEO in 1987, MHS was a very different health system from today. Under Mr. Sacco's leadership, the system has grown from one to six hospitals, a nursing home, home health agency and primary and urgent care centers that collectively employ more than 11,000 and work with 1,700 physicians.

We checked in with Mr. Sacco to glean some advice from his accomplished career. Here, he reflects on the importance of culture in driving growth, transitioning between leaders and what he looks forward to most come Feb. 29.

Question: Why did you go into healthcare?

Frank Sacco: It's interesting because I never studied for that; sociology was my major in college. I was commissioned through ROTC as an Army Medical Service Corps Officer and I caught the bug. I was stationed at Walson Army Hospital in Fort Dix, N.J. I was a medical supply officer in the Second Infantry Division stationed in the Republic of Korea, and then I served at the Madigan Army Medical Center in Tacoma, Wash. At that point, when I got out, I said, "This is the career I want."

I took a job outside of [healthcare] — a management training position — for five months, until I saw an opening at Memorial Hospital in Florida. I applied and didn't get it, but was offered another. I took the job to get my foot back in the door at the hospital and then went back to school for my master's [in healthcare management].

Q: Looking back on your career, what do you see as your greatest accomplishment?

FS: It was the development of both the culture of putting the patient first, as well as developing a high-performing, cohesive executive management team. I don't want to look at bricks and mortar — growing MHS from one to six facilities, including a first-class children's hospital known for heart transplants and soon-to-be doing kidney transplants — because the real accomplishment is developing this culture where everything we do, we do it around the patient and the patient's family. We define the family broadly, as whoever the patient considers family.

Q: As you mentioned, under your leadership MHS grew from one to six hospitals, and you were also able to develop a clinically integrated network of physicians and other hospitals. From your experience, what is your best advice to other administrators also trying to drive growth and clinical integration?

FS: The real key is first to define the culture and have that culture embedded in your healthcare system. When you do that, it's a lot easier to grow and expand. You can't ignore strategy, but a lot of people are really good at strategy, and where they break down is implementation. We excel at implementation. You can have a vision or strategy, but you have to be good implementers. That's critical.

If you have the culture that drives your system, it's easier to get physicians and employees on board as to what you want to accomplish — whether that's building another children's hospital, a rehabilitation hospital, a clinically integrated network or outpatient network — whatever it is, it's easier because they buy into the

"The real key is first to define the culture and have that culture embedded in your healthcare system. When you do that, it's a lot easier to grow and expand."

culture. That culture doesn't change as you grow your system.

Q: During your time at MHS, the system was also able to eliminate the use of tax dollars to fund uncompensated care. What strategies did you use to help accomplish that?

FS: First of all, we brought a strong financial discipline to the organization. We grew our brand through hospitals in the suburbs. We take care of all patients regardless of ability to pay, but the pay mix improves as you go into the suburbs. That's important.

Our managed care contracting and compliance strategies were critical to this. We made sure we were paid what we should be paid. We have a managed care compliance division separate from the normal revenue cycle division, so the person leading managed care contracting is also leading compliance. That helped us enormously. We moved our net revenue up to nearly $1.9 billion and collected $8 million in taxes. That $8 million in taxes only pays for the county's share of Medicaid Match.

The bottom line is we don't see a penny of the $8 million in taxes.

Q: As you transition between leaders, how does MHS maintain its momentum and success?

FS: I'm still the CEO, so the momentum is doing well. We have four internal candidates being considered by the board as my replacement, and they are doing a national search for outside candidates. The board has lost some of its traction — it got bogged down in processes I normally would have sped up if I were responsible.

Q: What has been difficult for the board?

FS: There hasn't been a search in the 60-year history of this organization. We're 63 years old, and it's the first time we've done a national search. The board wanted to make it transparent and had to retain a search firm, which took 2.5 months. When you have a board, everyone has an opinion. They burned through half of my notice going through that process.

A lot depends on when that candidate is selected and who it is. If it is an internal candidate, the transition will be smooth. If they come from outside, we have to see who that candidate is and how that will work. We may have to appoint an interim.

Q: What are you looking forward to most in retirement?

FS: I look forward to my own personal time. I plan to relocate to Ormond Beach — it's upstate about 250 miles north, on the coast. I'm going to renovate an older house and get a puppy. I'm a dog lover and I haven't had a dog for awhile, so I'm looking forward to getting reintroduced to my canine friends. I also have a cabin in northern Georgia, so I'll go hiking. My daughter is also having baby in February and my son is getting married in April, so I'll be busy. ■

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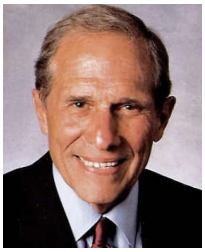
The Physician-Patient Relationship: Should it be 'Warm Detachment' or Breaking Down Barriers?

By Chuck Lauer, Former Publisher of *Modern Healthcare* and an Author, Public Speaker and Career Coach



When I was growing up, my mother and father always made sure that when they threw a big party, they invited the family physician and sometimes even their dentist. They weren't alone; it was a tradition back then to extend a courtesy to people who played any significant role in people's lives. Those memories came flooding back to me when I read an article in *The Wall Street Journal* about the so-called "new boundaries" between physicians and their patients.

I like to know as much as I can about any physician who treats me and my family. Where did they go for their medical degree and residency? Do they have a sense of humor? How do their peers feel about them? These may not be entirely clinical issues, but they factor into a relationship, which in my book factors into a good outcome. If you ask physicians for referrals to surgeons, they will recommend those they feel are most competent. They have seen them in action and have a pretty good picture of their surgical chops. But what I want/need from a physician may be entirely different from what others are seeking.

Professional organizations representing physicians are reserved on the subject of physician/patient relationships. For instance, Wayne J. Riley, president of the American College of Physicians, says doctors should "adopt a posture of warm detachment" with their patients. And other professional medical organizations are issuing new policies hoping to help doctors navigate the tricky patient/doctor relationship. Take the American College of Obstetricians and Gynecologists, which recently warned members against venting about patients — even anonymously — on social media. Then there is the American College of Physicians and the Federation of State Medical Boards, which released a policy statement in 2013 that included this advice to members: Physicians, they said, "should not 'friend' or contact patients through personal social media" or text "for medical interactions with even established patients except with extreme caution and patient consent."

A 2010 paper published in the *Harvard Review of Psychiatry* proposed rules for the phenomenon of what they call "patient-targeted Googling." Of some interest is the fact that in a survey of several dozen psychiatrists, most searched for information about their patients online. It warned doctors against doing so because of "curiosity, voyeurism and habit."

Some boundaries in the doctor-patient relationship are pretty clear: sex and romance are out. Physicians are advised not to treat their own family or close friends, situations that could compromise objectivity and judgment. But more and more, docs are getting more personal.

In the *Journal* article, Wanda Filer, a practicing family physician in York, Pa., and president of the American Academy of Family Physicians, states that she finds disclosing some information about her own life helps "break down that barrier as you build that relationship (between the doctor and the patient)." She feels that by being more open, patients "seem more willing to tell you other things that are going on" healthwise. Dr. Filer says she has attended the funerals of several patients and recently spoke at one. She even gives some patients her cell phone number. The intimacy she enjoys with her patients can also spill over to outside her office. "I've had patients have all sorts of graphic conversations at the gas station, the dry cleaners," she says. "They'll lift up their shirts up and show you a mole."

One irony of physicians becoming more open with patients is that in a 2004 study, when primary care physicians disclosed information about themselves, patients were less satisfied with their visits and were less likely to report feeling reassured or comforted. But when surgeons self-disclosed, patients were more satisfied and reassured.

Physicians in small towns say they have really no choice but to be close to their patients. Jen Brull, MD, is a family physician in Plainville, Kan., population 2,000. She sees her patients at her children's schools, at church and the grocery store. She lets patients friend her personal page on Facebook and invites them to the 5 a.m. exercise group she attends. "If I had to separate my patients and friends, I would either have no friends or no patients," she says, making her decision very simple.

The relationship between patients and their physicians is a most interesting and complex subject. As boundaries shift in our modern world, walking the fine line between appropriate and inappropriate "sharing" is going to take thought and good judgment. For me, appropriate sharing must be enough to have the information needed to build a trusting relationship.

Too often, bureaucrats and other outside parties forget how important a personal relationship can be, they make political decisions that often are detrimental to both physicians and patients. As with most clinical decision-making, how much to share — within the usual, common-sense boundaries — ought to be between the doctor and the patient. ■

The Corner Office: NYC Health + Hospitals Dr. Ram Raju on the 'Essentiality' of Public Hospital Systems

By Tamara Rosin

For someone who grew up with aspirations to design buildings, Ramanathan "Ram" Raju, MD, is constructing something else: change in healthcare.

Dr. Raju has served as president and CEO of NYC Health + Hospitals, the largest municipal healthcare system in the nation, since New York City Mayor Bill de Blasio appointed him in 2014. The $7.2 billion health system provides care to 1.4 million New Yorkers every year, including more than 425,000 uninsured, in more than 70 locations across the city's five boroughs.

NYC Health + Hospitals includes a network of 11 hospitals, trauma centers, neighborhood health centers, nursing homes, a large home care agency and post-acute care centers. NYC Health + Hospitals encompasses more than 70 community-based health centers, including Gotham Health, Federally Qualified Health Centers with 36 sites, OneCity Health — the largest performing provider system participating in New York State's Delivery System Reform Incentive Payment Program — and an accountable care organization. NYC Health + Hospitals also owns and operates one of the New York area's largest managed care plans, MetroPlus Health, with nearly half a million members.

Dr. Raju began his path to medicine and eventually healthcare administration in India, where he grew up, attended medical school and earned a master of surgery degree. Dr. Raju went on to study in England and was elected as a fellow of the Royal College of Surgeons. After arriving in the U.S., he underwent further training and worked as a surgeon in New York City, where he also took on leadership roles at NYC Health + Hospitals/Coney Island. Most recently, Dr. Raju was CEO of the Cook County Health & Hospitals System in Chicago, the third largest public health system in the U.S. There, he led a financial turnaround and spearheaded the creation of CountyCare, an Illinois Medicaid program to provide coverage for low-income adults in Cook County, ultimately leading to healthcare coverage for more than 170,000 residents.

Dr. Raju's dedication to public hospitals, advocacy for the poor and desire to alleviate healthcare disparities has driven him to lead momentous change for two major U.S. cities in addition to all of the lives he touched as a surgeon.

Here, Dr. Raju took the time to answer *Becker's Hospital Review*'s seven questions. *Note: Responses have been lightly edited for length and clarity.*

What's one thing that really piqued your interest in healthcare?

I came into healthcare by default. I wanted to be an architect, but growing up in India, parents dictate what career one chooses. My dad wanted me to become a doctor.

I no longer practice surgery, because as a surgeon operating on patients, you must be available to them at all times. It is important that you're not just there part-time. It's full-time or nothing.

What do you enjoy most about New York City?

New York City is a vibrant city. I love it for its diversity and culture. It is a city of immigrants — so many languages and cultures, so many ethnicities. It makes the city a very exciting and great place to live. There are also wonderful museums, Broadway, Central Park — everything you can think of.

If you could eliminate one of the healthcare industry's problems overnight, which would it be?

That would be the disparities in healthcare. When I practiced surgery, I was under the impression that we have the best healthcare delivery system in the world because I saw healthcare through my practice lens. I took care of everyone irrespective of their ability to pay, regardless of if they had insurance.

But I soon came to witness unequal treatment. It was clear to me that there are parts of the country and certain groups of people who do not get adequate healthcare, die early due to lack of access to healthcare, and even if they do obtain it, they don't have as good of outcomes as other folks.

This disparity exists in different parts of the country. It's something we need to eliminate. I don't know if I can eliminate it, but that's my desire. We need a healthcare delivery system that eliminates these disparities.

What do you consider your greatest talent or skill outside of the C-suite?

I feel strongly in the essentiality of the public hospital systems. I try to be a spokesperson for them, to articulate to people about how important the public health system is to the ecology of the national healthcare system. They have taken a premier role in taking care of the poor, those who are left behind. They are premier institutions of teaching, research and advancements in medicine. Those things are so important for people to understand and appreciate the need for public systems in the country. We need to cherish them, help them grow and keep them healthy.

How do you revitalize yourself?

I go to the gym, bike a lot and read a lot of books. I'm a member of a book club — there are a constellation of books I love to read and listen to. I mostly read about history and politics. I love biographies of presidents and other international leaders, books about the Constitution and Civil War biographies.

It is thoroughly fascinating to learn about the fathers of our Constitution. It is amazing how they created a document that still today stands tall. These people were very bright and driven by a great mission.

What's one piece of advice you remember most clearly?

My dad gave me a lot of advice. When I was young, I didn't understand it or value it, but as I got older I found all his advice to be true. One piece I still cherish today is: "Man's greatest enemy is his own self-importance."

What do you consider your greatest achievement at NYC Health + Hospitals so far?

Well, it isn't really my achievement but the achievement of my team and our employees, because I always say the greatest asset to our system is our workforce. We have some of the most dedicated and compassionate people who work very hard to take care of some of the most complex healthcare issues, and also try to solve social issues, such as homelessness, poverty, illiteracy and social isolation.

I think the fact that we exist and take care of one out of every six New Yorkers and don't turn anyone away is our greatest achievement. We provided services to more than 1.4 million New Yorkers last year and we are the largest provider of mental health services in New York City. We are really the social safety net for New York City. We take everyone and turn no one away. We provide excellent care — we have some of the highest quality indicators in the country. This isn't my achievement, but the group of people who work with us every day and my predecessors who made the system work better. ■

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Hospital and Health System Executive Moves

Mark Adams, MD, a board-certified general and vascular surgeon, was named CMO of Vancouver, Wash.-based PeaceHealth.

James Atkins, PharmD, was named CEO of Rutherfordton, N.C.-based Rutherford Regional Health System, a Duke LifePoint Healthcare facility, effective Feb. 8.

Vishal Bhatia, MD, was appointed senior vice president and CMIO for Franklin, Tenn.-based Capella Healthcare, effective Jan. 1.

Children's Health in Dallas made multiple leadership changes.**David Biggerstaff** was promoted to president of system clinical operations. **Michele Chulick** will become president of the newly formed Children's Health Ventures. **Robert Morrow**, MD, will become president of physician organizations and academic relations, in addition to his role as chief clinical officer. **Peter Roberts** will become president of population health and insurance services.

Cleveland-based MetroHealth System appointed **Bernard Boulanger**, MD, executive vice president and chief clinical officer, effective March 1.

Jeff Buckley was named interim CEO of Carroll County Memorial Hospital in Carrollton, Ky.

Christine Cassel, MD, president and CEO of the National Quality Forum, will leave her post March 1 to join the leadership team designing the new Kaiser Permanente School of Medicine in Southern California.

Patrick Chapman, EDD, was named CEO of Tippah County Hospital in Ripley, Miss.

The University of Kentucky in Lexington hired **Robert DiPaola**, MD, as dean for the college of medicine.

Indianapolis-based Indiana University Health appointed three executive leaders. **Al Gatmaitan** was named executive vice president and COO. **Ryan Kitchell** was named executive vice president and chief administrative officer. **Kevin Armstrong** was named chief mission and values officer.

Joseph J. Guarracino was named senior vice president and CFO of White Plains (N.Y.) Hospital, effective Jan. 11.

The Christ Hospital Health Network in Cincinnati named **Scott Hamlin** CFO.

USC Verdugo Hills Hospital in Glendale, Calif., named **Keith Hobbs** CEO.

David Koontz was named CEO of St. Francis Hospital in Columbus, Ga., the 376-bed facility recently acquired by Brentwood, Tenn.-based LifePoint Health.

Kenneth McFarland, CEO of Mission Hospital, with locations in Mission Viejo, Calif., and Laguna Beach, Calif., will resign in Februrary. He will be replaced in the interim by **Richard Afable**, MD, president and CEO of St. Joseph Hoag Health in Newport Beach,Calif.

David McQuaid's appointment as CEO of The Ohio State University Health System, and COO of Ohio State's Wexner Medical Center, both in Columbus, took effect Feb. 1.

Pikes Peak Regional Hospital in Woodland Park, Colo., named **Kim Monjesky** CEO.

Cynthia Moore-Hardy, president and CEO of Painesville, Ohio-based Lake Health, was elected board chairwoman of the Ohio Hospital Association for 2016.

Nathan Olson, president and CEO of St. Peter's Hospital in Helena, Mont., plans to resign from his post in May.

Annette Phillips, president of ProMedica Monroe (Mich.) Regional Hospital, is resigning.

Alecto Healthcare Services, the management company of Lancaster, Calif.-based Antelope Valley Hospital, appointed **John Rossfeld** CEO of the facility.

Steve Salyer, COO of Indian River Medical Center in Vero Beach, Fla., has left his position.

Peggy Sebastian, MSN, was named president and CEO of Belleville, Ill.-based St. Elizabeth's Hospital, part of Springfield, Ill.-based Hospital Sisters Health System.

Hancock County Health System in Britt, Iowa, named **Jeff Stampohar** administrator and CEO.

Milledgeville, Ga.-based Oconee Regional Medical Center named **Michael A. Vaughn** interim CFO.

David Wanger, CEO of Green Valley (Ariz.) Hospital, was scheduled to leave post Jan. 28.

Trinity Health-New England, a member of Livonia, Mich.-based Trinity Health, named **Scott Wolf**, DO, president of Mercy Medical Center in Springfield, Mass., and its affiliated entities. ■

Hospital & Health System Transactions

Athens (Ga.) Regional Health System's board of directors agreed to discuss a potential partnership with Atlanta-based **Piedmont Healthcare**.

After nearly 20 years under the ownership of for-profit hospital chains, **Bartow (Fla.) Regional Medical Center** was purchased by **BayCare Health System**, a nonprofit hospital network based in Clearwater, Fla.

Baylor Scott & White Health and **Tenet Healthcare**, both based in Dallas, completed a joint venture to own five Texas hospitals.

Horse Cave, Ky.-based **Caverna Memorial Hospital** became part of Bowling Green, Ky.-based **The Medical Center**, effective Jan. 1.

Charlevoix (Mich.) Area Hospital officially merged with Traverse City, Mich.-based **Munson Healthcare**.

Dallas-based **Christus Health** signed an agreement with **Coomeva Cooperativa Medica** in Colombia, under which Christus will assume partial ownership of several Coomeva subsidiaries.

Claxton-Hepburn Medical Center in Ogdensburg, N.Y., and **River Hospital** in Alexandria Bay, N.Y., entered into a cooperative agreement to affiliate under the name North Star Health Alliance.

Subsidiaries of Franklin, Tenn.-based **Community Health Systems** executed a definitive agreement to sell substantially all of the assets of Salem, N.J.-based **The**

Memorial Hospital of Salem County, along with its related outpatient services, to Ontario, Calif.-based **Prime Healthcare Foundation**.

Franklin, Tenn.-based **Community Health Systems** inked a definitive agreement to acquire an 80 percent ownership interest in **IU Health La Porte (Ind.) Hospital** and Knox, Ind.-based **IU Health Starke Hospital**. Indianapolis-based Indiana University Health will retain the remaining 20 percent ownership interest.

Financially troubled Los Altos, Calif.-based **Daughters of Charity Health System** closed a $260 million investment deal with **BlueMountain Capital Management** that will keep the health system's six hospitals afloat.

Brentwood, Tenn.-based **Duke LifePoint Healthcare** expanded its reach in North Carolina with the acquisition of two hospitals, which were previously owned by Dallas-based **Tenet Healthcare**.

Fairbanks (Alaska) Memorial Hospital is looking to cut ties with **Banner Health**, ending a 15-year affiliation with the Phoenix-based health system.

Oklahoma City-based **Foundation HealthCare**, which owns and operates surgical hospitals, acquired 69-bed **University General Hospital** in Houston, which filed for chapter 11 bankruptcy protection in 2015.

Amarillo, Texas-based **Harrington Regional Medical Center** is set to merge with the **Amarillo Area Foundation**. Nashville, Tenn.-based **Hospital Corporation of America** plans to create Palm Beach County's largest medical center with the merger of its **West Palm (Fla.) Hospital** and Atlantis, Fla.-based **JFK Medical Center**.

Johnson Memorial Medical Center in Stafford Springs, Conn., officially joined Livonia, Mich.-based **Trinity Health**'s New England region on Jan. 1.

Oakland, Calif.-based **Kaiser Permanente** signed a definitive agreement to acquire Seattle-based **Group Health Cooperative**, which includes a healthcare and insurance arm like Kaiser.

Brentwood, Tenn.-based **LifePoint Health** expanded its network with the acquisition of 376-bed **St. Francis Hospital** in Columbus, Ga.

Neptune, N.J.-based **Meridian Health** completed its merger with **Raritan Bay Medical Center** – a two-hospital system based in Perth Amboy, N.J.

Winston-Salem, N.C.-based **Novant Health** and **University of Virginia Health System**, based in Charlottesville, closed on a deal to create a new organization called Novant Health UVA Health System.

Columbia, S.C.-based **Palmetto Health** and Sumter, S.C.-based **Tuomey Healthcare System** finalized their merger, a deal which has been in the works since February. Boston-based **Partners HealthCare** and Medford, Mass.-based **Hallmark Health System** ended merger talks after putting the deal on hold earlier this year.

East Stroudsburg, Pa.-based **Pocono Health System** and **Lehigh Valley Health Network** in Allentown, Pa., signed an agreement for a full-asset merger.

Prospect Medical Holdings, a for-profit hospital operator based in Los Angeles, inked a definitive agreement to acquire Springfield, Pa.-based **Crozer-Keystone Health System**.

Salina (Kan.) Regional Health Center and **Cloud County Health Center** in Concordia, Kan., will enter into an operational and clinical affiliation beginning May 1.

Silverton (Ore.) Health, a single-hospital system, and **Legacy Health** in Portland are one step closer to joining forces, as the governing boards of each organization signed a definitive agreement that outlines how the two will come together.

Chapel Hill, N.C.-based **UNC Health Care** is adding **Wayne Memorial Hospital**, based in Goldsboro, N.C., to its hospital network.

University of Maryland Medical System and **Saint Agnes Healthcare**, both based in Baltimore, developed a formal affiliation to create a regional, clinically integrated health system.

Pittsburgh-based **UPMC** signed an affiliation agreement with **WCA Hospital** in Jamestown, N.Y., marking UPMC's first expansion into New York.

Dallas-based **Tenet Healthcare** and Marietta, Ga.-based **WellStar Health System** entered a definitive agreement in which WellStar will acquire Tenet's five hospitals in the Atlanta area.

Tyler, Texas-based **Trinity Mother Frances Hospitals and Clinics** signed a letter of intent to become part of Irving, Texas-based **CHRISTUS Health**.

The merger between **Yakima (Wash.) Valley Memorial Hospital** and Seattle-based **Virginia Mason Medical Center** was made official on Jan. 1 after the Federal Trade Commission approved the deal. ■

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