The Rise of Big Data in Hospitals: Opportunities Behind the Phenomenon

By Kathleen Roney

In and around the healthcare industry there has been a lot of talk about “big data” — very large sets of complex data that become difficult to process using database management tools. Big data is emerging in the industry because hospitals and health systems are collecting large amounts of data on patients every single day. The data comes for a variety of settings — clinical, billing, scheduling and so on. Unfortunately, in the past, a lot of that data was not leveraged to make patient care and hospital operations better. Recently, though, there has been a shift to change that.

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How Can Retail Health Help Hospitals Meet Health Reform Goals?

By Sabrina Rodak

In 2011, there were 1,355 retail clinics in the United States; this number is expected to more than double to 2,854 by 2018, according to a report from GBI Research. In addition, the number of patients visiting retail clinics has jumped from 1.48 million in 2006 to 5.97 million in 2009 — more than a fourfold increase, according to a study published in Health Affairs.

Hospitals and health systems are increasingly joining the growing trend of retail clinics by forming partnerships or creating their own retail clinics. The appeal of retail clinics for many hospitals is their ability to provide patients in increased access to high-quality, low-cost care — the top goals under healthcare reform. Here are six ways hospitals can align a retail health strategy with health care reform goals.

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Publisher’s Letter
February Issue; 2013 Annual Meeting

February issue. The February issue of *Becker’s Hospital Review* includes a special section of content on health information technology and information systems. HIT — once mostly a concern of CIOs — is becoming a greater priority for CEOs. As hospitals and health systems move toward pay-for-performance and population health management, information systems will be critical to success, and accordingly, health information systems are playing more and more of a leading role in organizational strategy. In “If Interoperability is the Future of Healthcare, What’s the Delay?” reporter Kathleen Roney explores why healthcare organizations in the U.S. have such difficulty “speaking” to one another through data and what can be done to remedy it. Other articles in this section explore HIPAA audits — yes, they’re coming — and mobile security of health information during what has been coined the “Bring Your Own Device” era.

This issue also contains our first annual list of “100 Hospital and Health System CIOs to Know,” as well as content on hospital-physician relationships and accountable care organizations, hospital finance, and hospital and health system transaction considerations.

4th Annual Becker’s Hospital Review Meeting. The 4th Annual Becker’s Hospital Review Meeting will take place on May 9-11, 2013, in Chicago at the Westin Michigan Avenue Hotel. We have expanded the 2013 event to a two-and-a-half day affair with even more speakers and panels, with even more speakers and panels, including 85 health system executives.

Keynote speakers include Lou Holtz, former college football coach and a sportscaster and author, and Patrick Lencioni, founder and president of The Table Group and author of 10 best selling books including “The Five Dysfunctions of a Team.” Bret Baier of Fox News’ “Special Report with Bret Baier” will also headline the event, serving as moderator for the meeting’s keynote panels. To learn more about the event, visit www.beckershospitalreview.com/4th-annual-beckers-hospital-review-meeting.html. To register, call (800) 417-2035 or email registration@beckershealthcare.com.

At the Annual Meeting, we will also announce winners of the 2013 Becker’s Healthcare Leadership Awards. Nominations are now being accepted. To nominate yourself or another industry leader, contact me at sbecker@beckershealthcare.com or Associate Editor Molly Gamble at mgamble@beckershealthcare.com.

Should you have any questions or if I can be of help in any manner, please do not hesitate to contact me. I can also be reached at (800) 417-2035.

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Vendor Neutral Archiving: Putting Healthcare Back in the Data Driver’s Seat

By Gregory Strowig, Vice President Client Services, TeraMedica, Inc.

For most hospitals, there’s nothing neutral about Vendor Neutral archiving — except perhaps the data itself. After years of relinquishing some, if not all, control of the Picture Archiving and Communication System and other important data to IT vendors, a VNA puts healthcare facilities back in the driver’s seat. Its benefits are significant: automatic access to a patient’s full clinical history across all providers; electronic medical records enriched with all patient images and reports — no matter the department or source of image generation; upgrading to a new PACS in just hours; and simplified and secure lifecycle management of the entire enterprise of clinical images, which account for the lion share of data storage demands.

VNAs are predicted to store 31 percent of all new imaging studies across the globe within four years, according to a major new report by InMedica, the leading independent provider of market research and consultancy to the global medical electronics industry. Christopher Roth, MD, associate chair of radiology for health information technology and clinical informatics at Duke University Medical Center and director of imaging IT strategy for Duke Medicine, says, “Having a technology that is fully compatible with the DICOM standard, and also provides flexibility for storing and managing our own data in both native and DICOM formats is essential. The ability to store such things as enterprise digital pathologic slides, visible light photos and DICOM radiology and cardiology clinical and research images is important to the success of our clinical and research missions.”

In addition to data control, the fundamental benefits of the VNA include interoperability among IT systems, easy medical record sharing and analysis and use of information in ways never before possible. In short, the VNA enables imaging sites to declare their data independence from the proprietary IT systems that often restrict the value of important medical information. That is why VNA has become one of the most talked about healthcare IT new technologies.

Standards-based storage

Unlike most PACS and other healthcare applications, a VNA follows storage methods and data formats that objectify healthcare information by adhering to industry standards. Additionally, IT applications are no longer tied to physically addressed storage and proprietary communication.

Underlying many of these benefits is a consistent metadata format, which enables identification of all data for a particular patient, wherever the information entered the IT system.

VNAs typically unify data from HIS, RIS, PACS and EMR, as well as information from numerous specialty departmental systems into a single archive.

Proprietary PACS problems: solved

Because diagnostic images and reports are among the most frequently shared information across the continuum of care, the isolated and often proprietary PACS archive has long posed a particular problem to hospitals — and to radiology departments that wish to upgrade to new PACS applications. The VNA provides an answer to PACS problems with implications across the enterprise and beyond.

The promise of an EMR enabled with DICOM images and related information is even more complex. This can require custom interface engines to link unrelated systems and possibly data transformation. It may even require the duplication of entire archives. Interfaces are costly to acquire, implement and maintain and create security risks and scalability issues. Data duplication significantly multiplies the storage and maintenance costs.

Moving all information to a truly standard DICOM eliminates most of these problems. With a VNA, sites can share images across systems, migrate to a new PACS and manage their data much more easily.

PACS beyond radiology and DICOM

The VNAs benefits do not stop with images — nor do the problems of PACS. Currently, a PACS is often called upon to store a growing variety of data — both DICOM and non-DICOM — from within radiology and from other medical specialties.

DICOM data stored may include cardiology, neurology and an ever-growing list of the “-ologies.” The departments that generate this data often have their own identification numbers, requisition systems and even accession numbers that all must be reconciled and managed within the PACS just to create an integrated record in this single application.

Adherence to IHE standards

A VNA takes advantage of standards developed by the widely recognized Integrating the Healthcare Enterprise initiative. In addition to DICOM, these include XDS and XDS-I, HL7 and others. Using this shared data format, the VNA provides one comprehensive archive as the single point of information access for all the healthcare IT applications connected to it.

Medical sites weary of the ongoing cycles of data conversion that accompany a move to a new IT application will be pleased to know that this will be the last data migration they will ever have to perform.

Applying standards to non-imaging DICOM objects and other data

The VNA also stores and manages non-DICOM information from other specialty IT systems across the healthcare enterprise. This typically involves such file types as JPEG, PDF, waveforms, various video and audio formats and MS Word — in short whatever modern medicine sends its way. In particular, these versatile storage capabilities make the VNA an appropriate repository for data from specialties as diverse as lab and ophthalmology to speech pathology and dermatology.

Some VNA providers can store non-DICOM data in native format, which provides for easy exchange of the originating system and allows departmental IT systems to retain some autonomy. Whether and how this is accomplished may vary significantly with the VNA vendor and has important implications for the true neutrality of the archive.

Interfacing with the EMR

Often, a key goal of the VNA is to provide access to complete, accurate and timely patient data at the point-of-care, typically through an EMR system. A VNA simplifies the task. A simple link to the standards-based VNA archive will bring up all these images and imaging-related data for a particular patient. Embed a lightweight DICOM viewer, and the result is an easy and elegant hospital-wide image viewing solution. Naturally, this same link and viewer can bring VNA information to any physician portal connected to the archive with a simple click.

Streamlining PACS migration

As a result, a site also has the ability to elegantly switch to any new standards-based PACS or other clinical system without costly data migrations or significant data reconciliation and cleansing. The VNA ends the era where a medical facility was tied to a particular vendor simply because its data was held captive in a proprietary format. Typically a new PACS can be connected to the VNA with a simple plug-in with little interruption of department functions.

Medical sites implement a VNA to achieve a wide range of goals, and the technology varies widely. Careful planning and an examination of the VNA marketplace will help ensure satisfaction with your VNA implementation.
leader in the area of innovation. Disruptive innovation transforms an existing market or creates a new market by making processes simpler and improving access.

Englewood, Colo.-based Catholic Health Initiatives, Salt Lake City-based Intermountain Healthcare and Appleton, Wis.-based ThedaCare have all employed disruptive innovation to improve quality and lower costs in the new healthcare environment. Here, leaders from each organization share some examples of how the system has created radically new models to disrupt unsustainable practices.

Catholic Health Initiatives
Healthcare delivery infrastructure
CHI has created a new infrastructure for the delivery of healthcare that shifts the central focus from the acute-care hospital to outpatient facilities and the home. “The healthcare delivery infrastructure is being replaced, at least conceptually, by new structures that revolve around physicians and other primary care service providers having more direct responsibility for patient care,” says Juan Serrano, senior vice president of payer strategy and operations at CHI.

CHI has expanded its relationships with physicians and has acquired other ambulatory organizations, including a home care services organization, to offer more outpatient care. Focusing on outpatient care and care closer to home signals a move away from a strictly fee-for-service system.

“We’re organizing our physicians, hospitals and ambulatory healthcare delivery network providers into a more rational system. We’re not waiting for people to become patients to serve them; we’re establishing more robust relationships in our communities to help people achieve and maintain their health while ensuring that essential medical care is delivered in the most appropriate settings — even when that means arranging for care outside our hospitals and specialist services,” Mr. Serrano says.

One of the keys to this new infrastructure is access to more data on patients that allows providers to manage population health. For example, CHI can access data on what services patients have accessed across the system, from their primary care physician to the emergency department to specific service lines.

Consumer orientation
Another disruptive innovation at CHI is an orientation toward patients as consumers and a greater connection between the system and community. “We are moving into a customer relationship management phase, investing time and energy resources in connecting with our patients and with consumers who are part of either employer groups or other defined populations that subscribe to our health system,” Mr. Serrano says. “As we identify people who are affiliated with the health system, we are [forming] connections intended to help address barriers to care.”

For instance, CHI may help patients arrange transportation to a medical appointment or help navigate financial assistance programs to pay for medications.

Intermountain Healthcare
In June, Intermountain Healthcare received a $9.7-million, three-year contract from CMS through its Health Care Innovation Awards for a project titled “Disruptive Innovation @ Intermountain Healthcare.”

“Through the shared accountability initiative, [the goal is] to really accelerate the transformation of healthcare,” says Lucy Savitz, PhD, director of research and education of Intermountain Healthcare’s Institute for Health Care Delivery Research.

Intermountain’s project focuses on three areas: physician compensation modeling, patient activation and population management. While the health system has not developed a definitive reimbursement model for physicians, it will incorporate incentives for quality and service and will move away from a strictly fee-for-service system.

Patient activation
The patient activation part of the project focuses on engaging patients in their healthcare decisions. Intermountain will use a tool called Archimedes Indigo to give providers and patients access to patients’ individual health information at the point of care. The tool will help patients visualize their condition and treatment options and will encourage their involvement in their own care.

For example, for a patient with diabetes, the tool would use the patient’s data to estimate the likelihood of developing other health complications and the effectiveness of different interventions in preventing these complications. The tool may show that quitting smoking may reduce the patient’s risk of death by a certain percent, and eating fish oil may reduce the risk by a different percent, Dr. Savitz says.

“It helps the patient understand what the patient’s role is in shared accountability in a way that’s not just general statistics; it looks at what is your risk based on your data,” she says. “It makes it more real, and the information more accessible. It helps take the dialogue in joint treatment planning between the physician and the patient to another level.”

Population health management/
Hot spotting
Another focus area of Intermountain Healthcare’s innovation project is population health management and “hot spotting” — identifying health trends in the community and implementing solutions to improve health. For instance, Intermountain identified a geographical area that included a senior center that had a large number of people go to the emergency department. To reduce the number of potential unnecessary ED visits, Intermountain plans to staff an advanced practice nurse at certain hours at the center to provide easy access to care.

“It’s really thinking about healthcare differently,” Dr. Savitz says. “We’re not just thinking about healthcare; we’re thinking about wellness. We’re not just thinking about patients; we’re thinking about people.”

As with CHI, increased access to data is one of

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the drivers of the disruptive innovations at Intermountain Healthcare. “The thing that’s different this time around than in the early ‘90s when we bent the cost curve is a better data system,” Dr. Savitz says. “We’re looking at taking the data system to the next level and employing it to our work moving forward.” Data plays a key role in patient activation, as it helps analyze an individual patient’s data and puts it in the context of risks for additional health problems and options for reducing risks. In the hot spotting project, data enables Intermountain Healthcare to identify and address patterns of care.

**ThedaCare**

ThedaCare was one of the first healthcare organizations to adopt Lean management as a method for process improvement, which is an example of disruptive innovation because it takes a new approach to improving care. Lean principles of process mapping, eliminating non-value-added steps and simplifying practices are based on the Toyota Production System and methods used in the manufacturing industry. By adapting this approach to healthcare, ThedaCare was able to make significant improvements in quality of care and cost.

Today, ThedaCare continues to employ disruptive innovation as a strategy for improving care. One example is its redesign of primary care, which began in 2007. In the redesign, providers at ThedaCare’s primary care offices changed their workflow to provide lab results for patients at the point of care. A medical assistant does the lab draw on site and the results are processed within 15 minutes, which allows the provider and patient to discuss the patient’s results and plan of care in one visit. Prior to this redesign, patients would have to come in for separate appointments to have a lab draw and discuss the results.

“It’s a revised flow that really concentrates on the patient experience,” says Jenny Redman-Schell, COO for physician services at ThedaCare. “We’re making sure that we’re identifying any waste within the process of the primary care office visit and trying to remove those wastes.”

In addition, the primary care office staff schedule the patient’s subsequent appointments during the same visit instead of leaving the responsibility of coordinating that care to the patient. The new process not only makes the provider visit more convenient for the patient, but it also increases the likelihood that the patient will follow through with his or her plan of care.

The key changes in the primary care redesign were adding on-site lab tests and processing within 15 minutes as well as ensuring patients leave with a plan of care. To implement the on-site labs, ThedaCare collected data on the most common labs at each office and acquired technology to perform those labs. “The lab work is something that we have not seen across the country at all, so for us to be able to draw the lab and process it within 15 minutes to get it to the provider is pretty transformational,” Ms. Redman-Schell says.

**Disruptive innovation — why it works**

CHI, Intermountain Healthcare and ThedaCare’s disruptive innovations uproot existing systems in favor of new approaches that simplify processes and reach new markets. These organizations recognized the need for a complete overhaul of healthcare delivery models instead of tweaks to the current system due to the rising cost of care, making them models of what can be accomplished through disruptive innovation.
“We’ve found that we can use the models to identify about 90 percent of MRSA in our patient population,” says Ari Robicsek, MD, vice president of clinical and quality informatics at NorthShore.

NorthShore has also used this modeling to predict which patients are likely to develop *Clostridium difficile*. “The hope is that with these models we will be able to perform special interventions on those patients at the highest risk of developing infection,” says Dr. Robicsek.

2. Reduced readmissions. Big data also provides predictive models for the likelihood of readmission within 30 days, which is another area NorthShore is targeting with its big data and informatics work, according to Dr. Robicsek.

“We will put data from the EMR into our enterprise data warehouse, which serves as a computation engine. We compute a patient’s risk of being readmitted in 30 days and then feed that data back into the EMR,” says Dr. Robicsek. “A user can look at a panel of patients to see which patients are at risk — high, medium or low — of being readmitted in 30 days.”

According to Dr. Robicsek, NorthShore uses a similar predictive model to identify patients who were recently discharged from the hospital with a high risk for readmission and then sends messages to primary care practices. The messages alert the patients’ primary care providers of their high risk and if they have any follow-up appointments scheduled.

“The practice could use the patient list to say ‘here is a high-risk patient with no follow-up scheduled. Let’s reach out to that patient and make sure we get them in for an appointment.’ We have already noted a substantial reduction in readmission rates,” says Dr. Robicsek.

Without large data sets showing trends and patterns in huge groups of patients, this type of accurate predictive modeling would not be possible.

3. Population health management. Big data also informs population health management as findings from predictive models can be shared with providers across the care continuum. According to Dr. Jain, big data offers providers the ability to use information and discover patterns in patient populations that may not have been possible before. The implications for better, coordinated and specialized care are endless.

4. Research advancements. Big data also advances clinical research toward new knowledge discovery quickly and efficiently. According to Dr. Jain, when large amounts of data are available, research does not become less traditional; rather, it becomes more meaningful.

“There was an old adage that it used to take around seven years for something to that was discovered in research to be applied in the care of patients. It’s called *bench to bedside,*” says Dr. Jain. “Lately, I’ve been using the term: *bench to bedside to bottom line.* The paradigm has shifted. The discoveries we are making with big data are informing decisions at a rate where the potential outcome — the bottom line — is more readily apparent.”

For instance, Dr. Jain was part of a study published in the *Journal of the American Medical Informatics Association* that replicated a study conducted in the Netherlands. Due to big data capabilities, Dr. Jain and his fellow researchers found similar findings with 10 times as many patients in a much shorter time period.

5. Operational improvements. According to Mr. Corcoran, big data can have an operational impact on hospitals as well because it provides hospitals and their staff performance metrics with which to compare operational efficiencies.

“When individuals can see their performance ranked among many others, it gives them more motivation to achieve better results. They have comparable, daily, real-time results, pushing them to deliver on those same levels,” says Mr. Corcoran.

In this sense, big data can have an impact from the back office all the way to inpatient care; rather than merely collecting the data, hospitals can analyze and operationalize it to inform decisions at a variety of levels within the organization.

“I’ve seen a dramatic difference in the time it has taken a nurse to insert an IV from a patient from one floor to another due in part to an awareness of performance metrics. Big data makes performance data even within a hospital more accessible so that efficiency and accuracy can increase,” says Mr. Corcoran.

Big data is emerging in the healthcare space, and it is likely that it will continue to magnify over time. According to Mr. Corcoran, healthcare organizations are going to keep collecting massive volumes of data, so aggregating and analyzing that data will be a continual challenge. However, that effort will be worthwhile as we begin to see the implications big data promises.

“For me, big data is about how to sift through the data to convert it to useful information — a more usable format and with the right visualization,” says Dr. Jain. “At the end of the day it is about making sure providers can do the right thing for the right patient at the right time. We are trying to improve healthcare for everyone.”

As the healthcare industry tries to improve the cost and quality of services for patients throughout the United States, healthcare organizations need to embrace the big data challenge. “Our institutional understanding has been that we need to be in a place where we are using this data to be competitive in the future and to provide the best care we can. Using the data has been an organizational imperative. There has never been the consideration of giving up,” says Dr. Robicsek.
access to healthcare services and hospitals’ access to patients, which can help hospitals coordinate patients’ care better.

Retail clinics provide additional opportunities to introduce patients to the hospital and its healthcare services. Hackensack (N.J.) University Medical Center formed a clinical collaboration with MinuteClinic, the retail healthcare division of CVS Caremark, in May. “It will help communities throughout our region in terms of Hackensack University Medical Center healthcare being extended through the retail health setting,” says Robert Garrett, president and CEO of Hackensack (N.J.) University Health Network, parent company of HackensackUMC.

2. Coordinate care. Hospitals can partner with retail clinics as a strategy to care for patients throughout the continuum of care, which can help improve the quality of care. “The retail health strategy gets into the overall strategy of building an integrated network,” Mr. Garrett says. “When building a network, it’s not just a network of hospitals; it also includes a network of providers, including physicians, ambulatory care centers and, in this case, retail healthcare.”

Hospitals can enhance the coordination of care for patients by connecting their electronic health record systems to the retail clinics they’re partnered with. This connection facilitates the transfer of patients’ medical information between different sites of care, such as between a retail clinic and a primary care physician.

3. Connect patients to primary and preventive care. Hospitals can also align a retail health strategy with the goal of improving population health — one of the triple aims of healthcare reform — by using the clinics as a way to connect patients to primary care and provide preventive care.

The word “retail” in “retail clinic” may not communicate the role of the clinics in promoting wellness and population health. “I don’t think of it as retail, I think of it as preprimary care,” says David T. Feinberg, MD, CEO of UCLA Hospital System and president of parent company UCLA Health System. UCLA Health System formed a clinical affiliation with CVS Caremark in July, which will make UCLA physicians medical directors for 11 CVS MinuteClinics in Los Angeles County. “From a health reform standpoint, [retail clinics] allow a lot of people with insurance and new people who will get insurance to access care and ultimately get into care appropriately so they have an ongoing relationship with a primary care provider,” Dr. Feinberg says.

In fact, the majority of patients who go to retail clinics do not have primary care physicians, according to Andrew Sussman, MD, president of MinuteClinic and senior vice president and associate CMO of CVS Caremark. “With the shortage of primary care providers expected to reach 40,000 by 2020 according to the American Academy of Family Physicians, we believe MinuteClinic will fill a vital role in patient care as we work collaboratively with teams of physicians and hospital systems to provide accessible and affordable care,” he says.

4. Increase convenience. Hospitals’ partnerships with retail clinics also provide a convenience to patients, which encourages patients to engage in their health — a critical part of meeting the healthcare reform goal of improved population health. Retail clinics are typically open on the weekend and have longer hours than physicians’ offices do. “The convenience part is an important one,” Dr. Feinberg says. “That’s the redefining healthcare part.”

Many UCLA employees have experienced firsthand the convenience that retail clinics provide. “As we were discussing [the retail clinic partnership] with the team, a confessional took place around the room, where people said, ‘I went to that MinuteClinic,’” Dr. Feinberg says. “These are our own people being treated at retail clinics. It was, in a confessional way, saying, ‘We’ve all been there.’”

5. Become patient-centered. Providing convenient healthcare services is one way hospitals are becoming more patient-centered in their approach to healthcare, a key change under healthcare reform. “It used to be that [healthcare] was hospital-based — all the doctors had their offices around the hospital. That’s provider centric. It made it easy for doctors, but not necessarily convenient for patients,” Dr. Feinberg says.

A patient-centered model is consumer-oriented, shifting the focus from providers’ needs to patients’ needs. Hospitals can meet patients’ needs by offering quality care in retail clinics. “The biggest piece [of surviving in a competitive health environment] is embracing a more consumer-oriented approach and not having the strategy be driven by the physicians in terms of what’s convenient to them,” says Matt Montgomery, senior vice president of the healthcare division of Buxton, a consumer analytics firm. “Rather, ensuring the strategy is driven by convenience to consumers, to patients — that’s the emphasis.”

6. Improve quality. One of the primary goals of a retail clinic partnership is to improve the quality of care, which is also a healthcare reform goal. Hospitals aim to improve quality through a retail clinic partnership by providing medical directors to ensure the clinics follow standard- ized, evidence-based care and provide care that is appropriate in a clinic setting. For example, the medical director may establish guidelines of treating skin infections for only patients under a certain age, or treating a fever only when it’s below a certain temperature, according to Dr. Feinberg.

Under both UCLA Health System’s partnership and HackensackUMC’s partnership, physicians will conduct a quality review of the MinuteClinic nurse practitioners and review their charts to ensure quality. “The nurse practitioners and medical directors are going to be reporting to each other on a daily basis with a rapid report, and with more in-depth reports on a weekly basis,” Mr. Garrett says.

Can a healthcare-retail partnership work?

Hospitals may initially have concerns about partnering with a retail clinic because of the differences between the health and retail industries. “We did have reservations about [the retail aspect],” Dr. Feinberg says. “[But] we experienced the value proposition ourselves. That’s how we got over the concept of retail.”

Hospitals can ensure the partnership will put patients first by confirming both parties share goals of increased quality of care and convenience for patients. “A lot of it has to do with making sure communication is clear, goals are clearly stated up front and both teams connect well together,” Mr. Garrett says.

While the retail clinics maintain retail’s focus on consumers — in this case, patients — the financial aspect of retail is not as prevalent. “We developed clinical affiliations, not legal partnerships. And there is no financial relationship,” Dr. Sussman says. “The model is for hospital system doctors to become our collaborating physicians.”

Mr. Montgomery says hospitals’ adoption of some strategies from the retail industry is a positive trend. “Retail clinics are the most critical intersection between healthcare deliver and a retail-like experience,” he says. “Healthcare has been long overdue in embracing a retail-like approach in terms of convenience and access to patients. We’re beyond the stage where it might be a fad, a trend; it’s a proven and established healthcare delivery model that is here to stay, and should be considered as part of [hospitals’] larger entry point strategy.”

Are retail clinics the way of the future?

As hospitals and healthcare systems continue to seek new ways to deliver high-quality, low-cost care, the prevalence of retail clinic partnerships may increase. “We feel partnerships of this kind, whether between a hospital and physicians or between a hospital network and a retail care center like MinuteClinic — that’s the way of the future; that’s how healthcare is going to be provided,” Mr. Garrett says.

Healthcare is moving to a model where more care is delivered in an outpatient rather than an inpatient setting. Retail clinic partnerships are one way hospitals can break into the outpatient market. “There’s no doubt that much more of healthcare will be provided outside the acute-care hospital setting. This is an example of where that type of healthcare can be provided in a coordinated, high-quality, cost-effective manner,” Mr. Garrett says.
Health IT Roundtable: What Are the Biggest Health IT Issues Going Into 2013?

By Bob Herman

Most hospitals and health systems across the country have had a laundry list of items on their health information technology checklists over the past several years, and refining the role of health IT will only become a more urgent and pressing issue as hospitals enter into year three of healthcare reform.

Here, five hospital and health system leaders — Rodger Baker, president and CEO, and Donna Staton, CIO, of Fauquier Health in Warrenton, Va.; Peter Banko, president and CEO of St. Vincent Health System, a Catholic Health Initiatives system based in Little Rock, Ark.; Chris Belmont, CIO of Ochsner Health System in New Orleans; and David Kaelber, MD, PhD, CMIO of MetroHealth in Cleveland — explain what health IT issues are at the top of their agenda next year, how “big data” should be interpreted in a health system, where telehealth fits into the picture and just how complex it can be to manage hundreds of different IT systems at once.

Question: Starting in 2013, what are the most pressing health IT issues and projects on your health system’s plate?

Rodger Baker: We have efforts going on with our small number of employed physicians. We needed to replace their electronic medical record, and coincidentally, at the same time, we talked to our primary care physicians about some of the changes that were coming down the pike with value-based purchasing and accountable care. Certainly, primary care physicians are going to be integral in all of this. We asked them what we can work on together. They needed some help in re-evaluating their own EMR. Donna has led the evaluation and selection of an EMR product that we hope to purchase. We hope to subsidize some of the first-year costs, and we have some monies in our capital budget for 2013 for these costs. This past year was big for due diligence. They learned a lot, we learned a lot, and hopefully we have a good product the community can rally around.

Peter Banko: We just went live with our EHR, which is part of a $2.2 billion effort by Catholic Health Initiatives. We are the first system to go live with the Cerner OneCare. It’s basically our shared, universal EHR, mostly on the acute-care side. We just went live before Thanksgiving. We also are doing a lot of work behind the scenes for data and clinically integrated networks, but our major thrust is this OneCare initiative with CHI.

Chris Belmont: Our strategic initiatives can be broken down into four big buckets: One, core systems replacement. We are getting ready for meaningful use and are getting everyone on a common platform to exchange information amongst the organization. We went to Epic because our legacy platforms couldn’t really support this. We are also doing that in the business areas, too. We are standardizing purchasing, payroll and the other business applications as well.

Two, infrastructure. How do we make sure [our technology’s infrastructure] is secure and meets security requirements going forward? We are going toward more electronic and less paper — so you have to have good disaster recovery and business continuity initiatives. We are drastically reducing downtime and increasing responsiveness as well. Building a stable, high-performing infrastructure is important as we go completely digital.

Three, user experience. [IT systems] are somewhat of a scavenger hunt. If you want information, you have to know what system to go to. We have 225 different applications and systems that we know of, and that includes systems for our cafes and coffee shops and our fitness center locations, for example. You have to know where to go and what password to use, and we are trying to streamline that user experience for our employees to make our systems more intuitive and user-friendly. One way to do that is to consolidate systems.

Four, analytics. How do we measure and do better with the data we have at our hands? That’s the real game-changer. That’s where we are going to focus a majority of our time. Healthcare is reactive, but we want to be proactive. We want to know what’s happening right now so we can manage the population one month from now. Let me know what’s going on with a population of diabetics, for example. How can I act on that to prevent them from having an event? Predictive analytics are going to be a game-changer.

Dr. David Kaelber: One of the top issues is meaningful use. Not only is it making sure we’re doing all things to be meaningful users now at stage 1, but how do we become stage 2 meaningful users as well? A theme related to that is enterprise-wide deployment of a single EHR. We installed an EHR, Epic, in the late 1990s; we installed outpatient Epic, then Epic in the emergency department, then inpatient Epic. But now, the real value of these systems comes from having the same system across all domains. One of the, I think, underappreciated values of health information systems is the ability to integrate with each other. We’ve got to go with a single vendor among all these different systems.

Another major item is we’ve invested in EHRs going on 15 years. We have the tools and a ton of data, but now it’s, “How do we use the tools with the data to really use the things that are meaningful to the healthcare system and our patients?” I’ve done work with Habitat for Humanity, and this is the analogy I use: The paper record is to the EHR as the manual hammer is to the power nail gun. If you know several skilled workers who know how to use a manual hammer, but you just give them a power nail gun and tell them to build a house, bad things can happen. There’s no guarantee of high quality and safety. Once you have access to the new tool, you have to ask, “How can I redesign how I build this house to take advantage of this new tool I have?” Ultimately, the house will be built cheaper and faster.
because you’ve redesigned the system with the power nail gun in mind. If you try to deliver the same system of healthcare with EHRs, you’re really undervaluing the power of the tool. You still want high-quality, safe, cost-effective healthcare, but you have to redesign the healthcare system with this tool at your disposal.

**Donna Staton:** Another one of Fauquier Health’s drivers is patient engagement as we look at how we create more engaged patients. There are multiple ways with which to do that. In the near term, we’re going to be rolling out a hospital-based patient portal. There will be standard capabilities such as paying bills online, looking at hospital records and so on. There will also be an “e-chart,” and we launched it internally to employees. The last thing is certainly meaningful use. We were a meaningful use early adopter, and we are prepared and are positioned for stage 2 in October 2013. ICD-10 readiness and other back-office capabilities are also important.

**Q:** As healthcare becomes more digital, how is your organization attempting to make sense of “big data”? How are you coordinating strategies to streamline patient data and have it make sense for everyone?

**PB:** St. Vincent, in particular, is doing work with our national colleagues at CHI. The platform we’re going for is consistent across CHI. The data we collect, and even for clinical pathways or order sets for physicians, are trying to be standardized across the country to set a standard around the quality of care that we provide.

**CB:** We are officially in “big data.” Our data warehouse just eclipsed 1 billion rows of data. There’s a lot of volume, velocity and complexity. We’re trying to reduce variability there. In order to control costs, you have to reduce variability in the way you practice. We have been engaged in this for three-plus years.

**DK:** This is a very important question. My view is that healthcare is still far behind a lot of industries in ways we have to think about data. The reason you want data is you want to improve some sort of outcome. You have to start with outcomes you want to improve, and then go back and see how you need to visualize data to improve those outcomes. For example, we were talking with a pediatric gastroenterologist. She was new here and said, “I think I can be helping a lot more patients than I’m currently referred.” You want to see more patients, so tell me what patients you want to see. She wants to see patients who are overweight and who need to have some recommended tests to see if there are liver problems. I said, “Wow, that’s something the EHR can help out with.” I can tell you who is overweight and who hasn’t had the necessary test, and maybe those are the people we want to alert. Don’t start with data. Start with a clinical issue you want to solve, and work backwards.

**DS:** As an organization, we are probably not as far along in that journey as I’d like us to be. To help us move forward, we do have some products [to organize data] that we use today that sit on top of our health information systems, and we have some big goals and objectives going into next year. It’s the analogy: We are data-rich but information-poor.

**Q:** What role are evidence-based protocols playing in your health IT initiatives?

**PB:** A large role — everything that we do clinically is evidence-based. We’ve taken this as an opportunity to consolidate practices. For example, our urologists in conjunction with CHI’s urologists worked together to standardize 15 different order sets, which was one for each doctor, and now we just have one for prostatectomy. We used this as an opportunity to change the process and standardize clinical order sets that are used by physicians and nurses as well.

**CB:** Epic has ability for best practice alerts, or BPAs. Evidence-based medicine is about if you do certain things at certain times on a certain patient, [treatment] can be predictable. For example, a patient comes in with a cardiac event. They come in during normal business hours, and their length of stay may be 1.5 days. But if they come in at Friday at 4 p.m., they don’t get an ultrasound until Monday, and the patient might be here for four days. It’s a length of stay issue that is inconveniencing the patient and costing us, the patient and the insurance company more. How do we apply the evidence we have to change behaviors? It may be having a tech on call at all hours to get the ultrasound, for example.

**DK:** We have a number of protocols on both inpatient and outpatient. One of the challenges is there are a ton of protocols. Some are evidence-based, some aren’t. In a given period of time, the evidence and protocols change. One of the strategic decisions I’m thinking about is how do we wrestle with that as a single health system? We are not experts in mining all guidelines out there. We need somebody to sort what important guidelines should be followed but also notify us when those guidelines change. I’m trying to get to the point where I’m not reactive. We’re trying to get a message from [another entity] to tell us the evidence has changed and the protocol is outdated.

**DS:** We are, up to this point, very manual in evidence-based medicine, but we have had more clinical decision support this year. Standardizing care to produce consistent outcomes is important, especially as we look at value-based purchasing and other quality indicators we’re going to be measuring. We’ve had a very loose process around that, but we’re trying to bring more governance and structure to that this next year.
Q: What about telehealth? How are you expanding technology within rural areas and areas with less access?

RB: We utilize telehealth right now. We have a certified telehealth stroke program through The Joint Commission. We only have one neurologist that will see patients in our hospital. But if a patient comes to the ED, they can connect in with eight other neurologists that we have a relationship with that can give advice to the ED physician. We think there's still more possibilities to expand telehealth in Virginia, especially with behavioral health. We need to figure out how to get more access to more people.

PB: CHI nationally is developing a telehealth platform for us. We are still in the infancy stage of that. In December, we launched a telehealth initiative with the University of Arkansas for Medical Sciences. Because UAMS is government funded, we assigned a team on how we can blend our two platforms together. We want to see how we can better reach out to [those in rural areas], initially in cardiology and neuroscience. Arkansas still has a lot of hospitals that are independent and unaffiliated, so it is a little bit of a longer process for us to deal with.

CB: We have a pretty strong and growing telemedicine practice. It started with our stroke telemedicine program that's now accredited by The Joint Commission, but the most innovative thing is our eICU program, through which we can monitor intensive care unit beds remotely. We can have one physician monitoring 80 beds, for instance. If there's an event, an alert may fire off. A nurse can also go in virtually, look at the monitor, medications and the chart in Epic and decide if any action needs to take place. The physician who is in the “bunker” with her can place orders and give instructions to nurses who are actually in the room. This will allow us to reach out to smaller rural hospitals that don't have the ability to keep intensivists on staff.

DK: This is an interesting area. I received an informatics scholarship studying telehealth. For our country, there's still a huge untapped potential for telehealth. Having said that, I'd break it down into a couple areas. There are three main areas for telehealth. One is provider-to-provider telehealth. For PTP, I'm a provider maybe in a rural area, maybe not, but I need help managing a patient. I want to reach out to another provider for their help in managing this patient. Two-way video is a common image that comes to mind. I actually think that's a relatively inefficient way for telehealth. The value of video for telehealth is just not always needed. I see the value in always seeing the patient.

A second area is home health or a nursing home. Maybe a patient connects with a provider and has a real-time cardiac monitor or digital scale. That's a big area of growth. But my view is we haven't reaching a tipping point in telehealth in the U.S. yet. There are regulatory and financial barriers. For regulatory, at least in 2012, in most states, your license to practice is geographically constrained. If I lived in Cincinnati, and people who live in Kentucky telehealth me from Kentucky, technically I can't help them. Some states are working on that now, though. Financially, from my view — I'm not an expert — most payors will not pay for anything except for a face-to-face visit.

I would argue the last type of telehealth is if I get a call or email about a medical problem, and I give you medical advice I'm liable for. In most medical settings, I can't charge for that. But in the grand scheme of things, if I can't be reimbursed for that, I'm limited in what I can do.

Q: Do you see population health management as the key driver behind health IT projects right now?

PB: We'll have a deeper data set [through our universal EHR], and we can link that across the continuum so you can move to population health. That's the next step for us. Building deep data in each clinical setting that will help us connect to population health.

CB: As healthcare morphs and changes over time with healthcare reform, we are going to be incentivized to manage the population and not admissions and visits. It's more beneficial for us, over time, to keep people from coming in. If we're capitated to cover that patient, it costs us every time they come in. It's also better for the community to keep everyone well. We need to use our tools to interact with patients — how can we prevent events from occurring? We're also going to be penalized for readmissions in the future. The areas we are focused on through technology are diabetes, smoking cessation, behavior changes and congestive heart failure. We need to start interacting with patients differently.

DK: Population health management is an important driver of some health IT projects. It follows the paradigm like when you asked about big data. My view is as a society, the healthcare system is still trying to wrestle with how much of our resources should be spent on population-level management versus how much should be based on a face-to-face level. You can see how this dovetails with healthcare reform. As of now, there are not a huge number of financial incentives for health systems to manage populations, but that will be changing. At least at [MetroHealth], it's raised to a higher level, and that will trickle down. Health IT tools will help with this.

DS: We've had a focus in the past year around the care continuum, especially certain populations. Like other hospitals and organizations in the industry, we are trying to figure out how we can gain traction in that front. We are targeting specific populations and are looking to mature that.
If Interoperability is the Future of Healthcare, What’s the Delay?

By Kathleen Roney

In order for the healthcare industry to move toward preventive care and population health management, clinical information needs to flow freely across networks and between hospitals and physicians. For this reason, healthcare organizations need interoperability — efficient yet secure means for IT systems and software applications to communicate and exchange patient data.

While CMS focused the latest stage of its meaningful use program on measures and objectives to encourage interoperability, the effect of that will not be seen until later in 2013 and early 2014 when providers begin to incorporate those measures and objectives into their clinical work.

At a hearing on electronic health records and interoperability in November, Farzad Mostashari, MD, National Coordinator for Health Information Technology, and Mark Probst, CIO and vice president of information services for Intermountain Healthcare in Salt Lake City and a member of the Health Information Technology Policy Committee, discussed the need for standardized exchange capabilities, which should help foster interoperability across the entire healthcare industry.

“We must set a clear road map and support an exchange infrastructure and the adoption of standards that will make it easier to share health information, so clinicians and patients have the information in the form and time they need to make appropriate healthcare decisions,” said Mr. Probst. “Presently, we lack a shared infrastructure and long-term plan to make this possible.”

Due to a lack of shared infrastructure among hospital IT and EHR systems, the healthcare industry has not reached the widespread interoperability it needs to foster preventive care and effective population health management. To correct this issue, there are barriers and issues that must be addressed.

1. Executives need to educate themselves on IT options. Moving forward, hospital executives need to educate themselves on systems, products and vendors that will help them reach interoperability; they need to be educated consumers of IT.

According to Patricia Katzman, director of interoperability and CDS marketing and strategy at Philips Healthcare, executives need to be asking about standards and profiles for interoperability when they make IT purchases, and about more than just their hospital’s needs. Without knowledge of industry norms for products and systems, executives could agree to purchasing systems that do not offer the capabilities they need.

“It takes time to learn, but it is worth the effort. Demands for standards-based interoperability systems from purchases can make a difference in vendors supplying truly interoperable systems,” says Ms. Katzman.

Dave Caldwell, chief of marketing and sales of Certify Data Systems, argues that executives need to be thoroughly educated so they have the knowledge to discern technology that will deliver on interoperability rather than just promise it.

“The message is buyer beware. Make sure you fully understand all the aspects of the technology and what it can do for you. Don’t take suppliers on face value. They can mislead healthcare executives when they are trying to make a sale,” says Mr. Caldwell

2. Interoperability needs to include semantics. Many IT products and software are not semantically interoperable with each other, which is another major barrier toward reaching interoperability within the healthcare industry and across providers. For instance, one system might call a heart attack a myocardial infarction in its EHR, and another might call it a heart attack. While clinicians know that means heart attack, unless the system is digitized with that standard, it may not recognize the two classifications as one and the same.

Semantic interoperability is interoperability at the highest level because it involves the structure of the data exchange and the codification of the data so a receiving IT system can interpret the data. This will become more important as providers go to risk-based payment models and attempt to manage populations. According to Mr. Caldwell, when data is brought into a data analytics tool or shared via health information exchange, it needs to be standardized as either a myocardial infarction or heart attack, not both.

“If this is a problem while sharing information, it won’t be the straw that breaks the camel’s back. However, when providers move to population health management, it will be crucial,” says Mr. Caldwell.

3. Products and software need to be developed to fit existing infrastructure and systems. Strong infrastructure within a hospital is necessary for interoperability, and Ms. Katzman believes that strong interoperability stems from product and system compatibility.

Since interoperability relies heavily on IT infrastructure, if software products cannot be integrated into existing infrastructure, hospitals may have more difficulty exchanging data.

Some products are easier than others to fit into a hospital’s IT environment — some have a smooth fit and others require extensive customization. As vendors develop products, they need to develop them with the hospital’s environment in mind, says Ms. Katzman.

According to Jason Martin, senior director of integration, interoperability and database information and information technology for The Mount Sinai Medical Center in New York City, the industry needs to be focused on more plug-and-play capabilities between disparate systems — leveraging the existing standards and focusing on quick solutions to enable data exchange.

“[Vendors] need to play well together to augment an environment conducive to information exchange. There are multiple interpretations of data needs and it differs from vendor to vendor,” says Ms. Katzman. “When implementations of vendor systems require over-customization such that data meanings must be constantly interpreted for machine-to-machine communication, it adds cost and complexity to the implementation without adding value to the healthcare industry.”

Kumar Chatani, senior vice president of information technology and CIO of The Mount Sinai Medical Center, agrees. “I believe that EMR vendors need to make it easy to exchange data between the various systems. This should be standards-driven and inexpensive like electronic data interchange transactions,” says Mr. Chatani.

4. Hospitals need to distinguish data types to strengthen internal interoperability. “Some may think interoperability is just about sharing information, but it is important to note where and to what systems [providers and hospitals] are sharing data,” says Ms. Katzman.

Information from a variety of levels within a hospital — point-of-care, departmental or enterprise — can be shared. Departmental level data may
have department-specific information as well as patient and clinical diagnostic information. Enterprise-wide data may include this departmental information as well as data from an electronic medical record with a patient’s address, phone number or allergies. In order for interoperability within a hospital or health system, the network and infrastructure will need capabilities to collect, aggregate and manage each data type.

According to Mr. Caldwell, hospitals have struggled with internal interoperability — sharing point-of-care, departmental and enterprise data among departments and facilities — for years.

True interoperability involves intelligent bridging — not just connecting — information, according to Ms. Katzman. A hospital's utilization of the information is important as there are different products and systems necessary for sharing data at the point-of-care, departmental and enterprise levels.

5. Hospitals need interoperability with physician groups and the community. While interoperability is not perfect in internal scenarios, Mr. Caldwell believes that hospital executives should place focus on interoperability with partners in the community as well because it is where they have placed the least amount of focus.

"[With all the different IT systems being used], it is like all the physicians in a community are living in different countries, speaking different languages. How do you start to become interoperable when no one is speaking the same language?" asks Mr. Caldwell.

Some organizations that have affiliated with, or even acquired, physician groups can use a single EHR platform across all their facilities. According to Matt Jackson, director with Pro-tiviti, a global consulting firm with a focus on IT and internal audit consulting, the OCR intends to develop a permanent audit program based on findings from the pilot audits. “It is still very likely that hospitals can be audited as part of the pilot. In addition, [OCR] fully expects that the process and the audit protocol will expand, and additional organizations will be audited,” says Mr. Jackson. If a hospital is not selected for an audit under the pilot program before December, they may still be subject to future HIPAA audits under the expanded program.

“It is not a matter of if a hospital will be selected but when,” says Reza Chapman, senior manager and one of the leaders of Ernst & Young’s information security and privacy services practice. Preparing for a potential audit — and HIPAA compliance in general — can be an overwhelming and time consuming initiative. In the face of stage 2 meaningful use, ICD-10 and other industry initiatives, hospitals may sideline audit preparations. However, any hospital could still receive an audit notification, so delaying preparations could be disastrous. When a hospital receives a notification, they only have 15 days to gather all the necessary material. In order to avoid the scramble, hospitals should prepare as if they will definitely be audited. If they do not receive a notification, then they will be prepared for a potential audit in the future. “Hospitals should be taking action right now. Assume the worst-case scenario — that you’ve been selected for an audit and have only two weeks to prepare,” says Mr. Jackson.

Here Mr. Jackson; Mr. Chapman; Damon Petraglia, director of forensic and information security services for Chartstone Consulting and former federal contractor for HHS; and Mahmoud Sher-Jan, CHPIC, vice president of product management for ID Experts, discuss nine ways hospitals can adequately prepare for HIPAA audits and achieve success in the overall privacy and security of electronic personal health information.

1. Become familiar with audit protocol. Hospitals need to be familiar with the audit protocol, which is essentially a guide to what auditors will want documentation of during an audit. According to Mr. Chapman, remarks from OCR Director Leon Rodriguez have suggested there will be little leniency for HIPAA noncompliance given the 15-year history of HIPAA and the substantial technical assistance made available to hospitals. While it may seem intuitive, if a hospital has not thoroughly reviewed the protocol, it should. “Hospitals would be wise to leverage the publicly available audit protocol as they prepare for potential audit. It is a key step to determine what documentation the hospital would need if it were to receive a notification letter,” says Mr. Chapman.

The audits will analyze processes, controls and policies of hospitals pursuant to the HITECH Act. OCR’s comprehensive audit protocol contains requirements to be assessed through the audits. The protocol includes 168 performance criteria — 78 for security, 81 for privacy and 10 for breach — which detail key activities hospital management should implement to ensure HIPAA compliance.
According to Mr. Chapman, OCR intends for the audits to serve as a compliance improvement tool rather than an enforcement tool. However, if OCR does uncover serious compliance issues it could trigger a separate enforcement investigation, which could lead to sanctions, other penalties and corrective action plans.

“Hospitals have 15 days to prepare documentation related to the audit and are not afforded additional time to respond. Missing elements will be noted by the auditor and appropriate observations made. It will be up to the OCR to determine whether the missing elements necessitate a separate enforcement investigation,” says Mr. Chapman.

2. Update and maintain documentation. Since auditors will request documentation from hospitals during an audit, one of the most important preparatory steps for a hospital is to maintain sufficient documentation of its efforts to follow and meet the audit protocol. “Documentation is a hospital’s evidence. It should tell the hospital’s compliance story to an auditor with little or no additional explanation needed. If a hospital is not prepared — if plans, procedures and actions are not in place — it becomes apparent quickly to [the auditors],” says Mr. Sher-Jan.

According to Mr. Jackson, if a hospital is missing the proper documentation, the auditors will assume the hospital did not meet the compliance element. “For example, hospitals are required to document where the PHI resides, the potential threats and vulnerabilities to that PHI and a plan to mitigate those risks. If the hospital does not have that documentation to turn over, it is reasonable to anticipate that the auditors will assume it did not go through the process,” says Mr. Jackson.

3. Review results from initial pilot audits. According to Mr. Jackson, it is important that hospitals continuously monitor regulatory developments from the pilot audits. “Keep track of the regulatory updates and guidance, and look at areas in your hospital that have been identified as pain points from the initial audits,” says Mr. Jackson. While OCR is not sharing results from all of the pilot audits because of the potential risk to organizations being audited, it does expect to share high-level guidance and preliminary results in areas where the most significant weaknesses were found. “It is a logical step for executives to review OCR findings and to assess where the hospital stands in those areas,” says Mr. Chapman. OCR has already revealed the following five areas of weakness from the initial audits.

- User activity monitoring
- Contingency planning
- Authentication and integrity
- Media reuse and destruction
- Risk assessment

4. Assess current HIPAA program governance. One of the best ways for hospitals to prepare for audits is by assessing current security and privacy governance structure. “In order for organizations to align with HIPAA rules, they need to make sure they have set up strong governance. How are they addressing the challenge of HIPAA? Are the right stakeholders engaged in the process? Do they have the right executive support to drive out the process as well as technical changes to address HIPAA rules? Clear governance needs to be established,” says Mr. Chapman. In addition, hospitals should have conducted an evaluation of its compliance within the last two years. “Is the hospital doing what it needs to meet requirements? Someone should have looked at the audit protocol checklist and analyzed what the hospital has done to comply and mitigate associated risks,” says Mr. Jackson.

5. Update the risk analysis. While a risk analysis is just one element of OCR’s guidelines, it deserves a great deal of attention because it is one of the most challenging areas for an organization to accomplish successfully. A thorough risk analysis involves outlining the risk needs of the hospital, collecting data to understand the flow of personal health information across the hospital, identifying and documenting potential threats and vulnerabilities, assessing current security measures and determining the likelihood of threat occurrence. According to Mr. Chapman, the last step — determining the likelihood of threats — is often the least considered element of a risk analysis. “OCR provides guidance that a hospital should conduct a risk analysis, but it is not very specific. In the end, it is up to the hospital to perform a thorough analysis,” says Mr. Chapman. “Part of the challenge is just doing the risk analysis. However, hospitals need to stay away from a control-based risk analysis where they go down the auto protocol like a checklist. Merely checking an element off the list will not satisfy the risk analysis requirement,” says Mr. Chapman.

6. Run internal “mock” audits. In addition to updating risk analysis, a hospital should run a “mock” audit because it is an accurate, effective method to reach optimal security. “If a hospital finds weaknesses in its privacy and security, it can improve those on its own timeline, instead of OCR’s. In addition, it allows the hospital to iron out weaknesses without the pressure of an audit,” says Mr. Petraglia.

7. Change your mindset. According to Mr. Petraglia, in order for mock audits to be useful, executives need to have the mindset that findings are a good thing. “Management is usually worried by audits. The truth is that findings are good because you discover vulnerability in the hospital’s processes, and you can do something to correct that. If you do not know about the weakness, the hackers will find it,” says Mr. Petraglia. The time to be worried about findings is during a second audit. “You do not want to have more findings in a second audit than in a first audit,” says Mr. Petraglia.

8. Focus on the “spirit” of the audit. It is very easy to follow the audit protocol as a checklist, but when a hospital’s only goal is to be compliant, they may miss the “spirit” of the audit and overlook strong security safeguards. “There is a tremendous difference between compliance and security. Security is the mechanism to ensure privacy. When a hospital concentrates solely on compliance — being compliant with the wording of the HIPAA rules — it may limit itself and miss important security elements. You want to make sure you are focusing on the spirit of the audits — the privacy and security of patient information,” says Mr. Petraglia. He recommends that hospital executives go through the audit protocol with the broader picture in mind. What is the goal of each element for security purposes? Why has OCR included these elements?

9. Discuss the process with other hospitals. If an element of the HIPAA rules or the audit protocol is unclear, hospitals should reach out to OCR as well as other hospitals and health systems. “The best thing that hospitals can do is to talk to each other. All the healthcare organizations can benefit from open communication and collaboration. If hospitals can share how they solved security problems and approached compliance, it will establish industry best practices,” says Mr. Petraglia. The establishment of best practices will help hospitals apply techniques to situations that may be unique to their organizations. “[Hospitals] may be in different stages of sophistication for their culture of compliance. If they have access to best practices, they can implement them in regard to their own businesses’ processes and needs,” says Mr. Sher-Jan.

The audit pilot program is only the second of three phases of OCR’s health information privacy and security compliance program. The first step, now complete, was developing the audit protocols. The third step, which was planned to begin after the pilot audits finished in December, is performing complete audits with revised protocols. For this reason, all hospitals and health systems should be moving toward better security and privacy of patient information with the audit protocol and HIPAA compliance as a guide. Regardless of inclusion in the pilot, all healthcare organizations may be audited in the future with new protocols. Beginning preparation now will be the difference between hospitals that do well during audits and those that do not.
Medical Device Interoperability Presents Patient Safety Challenges, Opportunities

By Sabrina Rodak

While health information technology has the potential to make significant improvements in efficiency in healthcare organizations, it presents patient safety risks. In November, the Institute of Medicine published a report calling for an increased focus on health IT and patient safety and recommending 10 actions for HHS. Medical devices have also garnered attention for their risks to patients. The ECRI Institute listed several medical device-related issues in its list of the top 10 health technology hazards for 2012. Fifth on the list is “inattention to change management for medical device connectivity,” which can cause problems with interoperability.

However, medical device interoperability can allow different systems to share clinical data to manage patients more effectively. For example, smart pumps allow different brands of pumps to communicate with each other to ensure that a patient does not receive an overdose or incompatible medications. Other interoperable medical device possibilities include connecting alarms to electronic medical record systems and infusion pumps with a pharmacy system, according to Elliot B. Sloane, PhD, CCE, professor and director of health systems engineering and founder, president and executive director of the Center for Healthcare Information Research and Policy at Drexel University School of Biomedical Engineering in Philadelphia.

To ensure patient safety while gaining the benefits of medical device interoperability, the United States needs to develop updated regulatory guidelines, Dr. Sloane says. The FDA released draft guidance on oversight for mobile medical applications in July, but it included unnecessary regulations and did not promote innovation, according to comments submitted to the FDA by the mHealth Regulatory Coalition in October.

The field is young
One of the reasons the industry needs updated guidelines is because interoperability between medical devices is a young field. “Formal IHE [Integrating the Healthcare Enterprise] profiles for patient care devices are only five or six years young,” says Dr. Sloane. IHE profiles are protocols that allow different systems to share data. While profiles for blood pressure monitors and early infusion devices have been developed, they are only beginning to be implemented in alarms, according to Dr. Sloane.

An advantage of being a young field is the ability to anticipate and adapt to changing trends. For example, some companies are now manufacturing products with interoperability capabilities built into the system. “We can look forward with a sense of awareness that tomorrow’s technology will be very facile, embracing things like apps,” Dr. Sloane says. In addition, medical device interoperability can pull from related, more established fields, such as clinical engineering. As a less established area, however, current regulatory processes are inadequate.

The need for a new regulatory framework
“One of the conundrums is medical devices as a category have always been highly regulated,” says Jim St. Clair, CISM, PMP, SSGB, senior director of interoperability and standards at HIMSS. “On the other hand, the iPhone has no regulation. From a compliance standpoint, the juxtaposition of regulations and the growth of technology and wireless communications is a challenge [going] into 2013.”

Dr. Sloane suggests the need for new certification methods and safety management methods for an industry in which the HITECH Act and healthcare reform laws have spurred enormous growth in a short period of time. In fact, the IOM report recommended HHS urge Congress to establish an independent federal entity for investigating patient safety deaths, serious injuries or potentially unsafe conditions associated with HIT. “We need to develop a new paradigm of regulation,” Dr. Sloane says. “The prior paradigm was based on box-level or unit-level certification — [an] infusion pump or heart monitor is certified by itself. We’re evolving into an interoperable, interdependent world where everything has to work [together].”

One way to work toward a new regulatory model for medical devices is to study and test interoperable systems. “To the extent we can establish reliable interoperable demonstration platforms or case studies, we can help in the exploration of the risks and safety challenges of converging medical technology, information technology and electronic health records,” Dr. Sloane says.
9 Best Practices For Hospital Data Security in a “Bring Your Own” Era

By Kathleen Roney

The mobility of patient data — made possible by new technologies and the proliferation of mobile devices in the workplace — is a leading factor in data breaches. According to Kroll Advisory Solutions’ “2012 HIMSS Analytics Report: Security of Patient Data,” 31 percent of healthcare organization respondents indicated that information available on portable devices is among the factors most likely to cause a data breach. This factor is amplified by what some have termed the BYOD — “bring your own device” — and BYOC— “bring your own cloud” — era.

The “bring your own” era

According to Alan Brill, senior managing director of Kroll Advisory Solutions, while BYOD is a problem in the healthcare industry, BYOC is almost more threatening to the healthcare industry. Moving data or information has become easier because of the emergence of consumer-friendly and easy-to-use cloud storage services. Many companies have offerings such as Microsoft, Google and Apple. There are even individual companies, such as Dropbox, that offer cloud storage, hence “bring your own cloud.” Data and information is easily transmitted with these cloud services. Unfortunately, that also means that the physical location of data may be less secure, and in a healthcare setting, insecure data can be extremely damaging.

“You would probably expect that anything a hospital would store in a cloud server would be encrypted so that even though access may be easy, not just anyone could open the file and read it. However, given the immediate availability of cloud service tools, if someone wanted to move data for any reason — lawful or not, reasonable or not — the ability to do so is very real,” says Mr. Brill.

Gone are the days when stealing hospital data was difficult because of the physical volume — the boxes and boxes of physical files. Stealing or losing healthcare information is easier because of gigabytes and megabytes of storage available on commercial cloud storage tools and USB ports.

In order for hospitals to combat the vulnerabilities of BYOD and BYOC, they need to be vigilant with data security to protect health information.

1. Learn from other’s experience. Many hospitals struggle with data security inexperience. Those running the security initiatives are doing so for the first time. While individual elements are not complex, hospitals will benefit more from experience to address complex problems. However, the experience does not have to come from an HIT consulting or software solutions company. It can come from other institutions in the community or from professionals groups in the field where industry information and white papers are shared.

2. Conduct a regular data census. It is imperative that hospitals conduct regular data censuses — just as they would conduct an inventory of surgical instruments — to get a handle on what data is being stored and where. “Many times when data is stolen from a hospital, the executives are shocked to find out where the data was stolen from. I often hear ‘I didn’t know we still had that patient information,’” says Mr. Brill. Over time, a hospital collects a great deal of patient health and financial information, and managing the data can become cumbersome. However, it is necessary to track the data regularly so it does not become what Mr. Brill terms “vampire data.”

3. Do not keep data longer than necessary. A hospital’s patient data has an initial asset value, but over time, the value decreases. When that data is stored past the required timeline of seven years, it may be more of a liability than an asset. “Management may determine that some forms of data have significant value even though they are legally mandated retention period is over. My recommendation is that they do an assessment to see if they should keep it or securely get rid of it,” says Mr. Brill.

4. Implement a strategy that accounts for multiple technologies. Since mobile technology is evolving at such a rapid pace, it will be important for organizations to monitor what operating systems employees are using, what updates and security patches are available and what new tools are emerging to mitigate risks. Further, in a “bring your own device” environment, it is much easier for users to download personal applications and questionable content that may put devices at risk. Hospitals need to consider these issues to maintain a reasonable level of security.

5. Ensure users are employing standard security settings on their devices. Regardless of whether or not an organization allows BYOD, some security practices should be non-negotiable. Chief among these practices are passwords, firewalls and anti-virus programs. Depending on the type of information the employees will be accessing or transmitting, encryption should be a necessary component. It may also be prudent to equip mobile devices with remote-wipe applications, so that data can be easily erased should the device be stolen.

6. Help employees understand and comply with company policies. This is vital with “bring your own device,” because even if employees are using their own devices, they will still have to employ basic security features as a requirement of accessing company information. To achieve the level of compliance needed, it will likely be necessary to employ a combination of user training — via a formalized program — and technical support. Accessible training and support can help reduce “security work-arounds.” When employees understand the purpose of security applications or procedures, they are less likely to attempt to circumvent or disable them.

7. Supplement employee education with technology. Although hospitals can train and educate employees on security policies, they should still implement technology to detect security breaches or mistakes. “While the vast majority of individuals are going to and want to do the right thing, hospitals should still have the protection in place. The technology tools will help employees follow the rules,” says Mr. Brill. The technology can be anything from disabling USB ports to blocking use of personal email accounts or cloud services like Dropbox.

8. Remain aware of the threat of lost or stolen devices. Despite new and emerging threats, lost and stolen devices still dominate as a cause of data breach. With BYOD, the lines of ownership may appear blurred to the user, and he or she may not know their work-related responsibilities with regard to lost devices. Hospitals should make sure employees know what to do if they lose their devices and have a plan in place to determine if any sensitive information was stored on it.

9. Continue to reassess the efficacy of BYOD, BYOC. According to Mr. Brill, hospitals should keep in mind that data security is not a “set it and forget it” decision; rather, it is one with almost continual consequences in terms of risk. It will be important to monitor the time, money and resources that are devoted to maintaining security in the wake of commercially prevalent mobile devices and cloud sites to determine if this model is effective for the hospital.
How Does the Rise of Computers in Exam Rooms Impact Patient Care?

By Kenneth Bertka, MD, Vice President of Physician Clinical Integration, Mercy

The introduction of electronic health records is transforming the healthcare industry and patient care. With the advent of EHRs, a physician has a patient’s medical history along with access to evidence-based guidelines at his or her fingertips. However, getting this information at a physician’s fingertips involves a fundamental change to the traditional patient exam room interaction. Now, physicians or other clinicians must search for and enter information into computers or other devices while treating a patient. This computer-physician-patient interface is taking place every day in exam rooms, and its impact on patient care and patient satisfaction isn’t yet fully understood.

A mixed blessing

The presence of computers in exam rooms can be a mixed blessing. Certainly, having information immediately available to physicians that can inform decision making or be shared with a patient is a positive change. The challenge is: How does a physician’s interaction with a computer interfere with the interaction between the physician and the patient? If the physician is too focused on entering information into a computer and not connecting with the patient, that’s a problem that needs to be addressed.

Certainly, computer-physician-patient interaction is an area that needs a lot of research and development. Medical schools are just beginning to explore how care is impacted by EHRs and sharing best practices with their students; much more research should be expected in years to come. For now, though, clinicians should take a “back-to-basics” approach when interacting with patients—and computers—simultaneously.

Back-to-basics best practices

Clinicians must continue to make eye contact with patients, especially while the patient is speaking, to show they are listening to what the patient has to say. Because clinicians may need to enter information while the patient is speaking or shortly after, it is helpful to have the exam room arranged in a way that allows the clinician to enter information without sitting with his or her back to the patient. This can be a challenge because often exam rooms are retrofitted for computer equipment, not designed with it in mind.

I believe that a half-moon (semicircular) table with the flat side against a wall and the patient and physician sitting along the curve with the computer monitor on an adjustable arm in the center helps encourage physician-patient interaction. The physician can maintain eye contact with the patient by looking past the monitor and can pivot the screen toward the patient to share test results or educational materials.

Computers should also be placed so that physicians can use them while seated. Several studies have shown that patients rate satisfaction with their physician higher when the physician sits during the encounter rather than stands. In a hospital setting, computers are often placed on movable carts; given that patients prefer physicians who sit, these carts should also adjust up and down. Ensuring a computer is placed on an adjustable cart may seem like a minor modification, but its impact may significantly affect patient experience for the better. If space permits in an office setting, the cart can move along with the physician as he or she sits and takes the patient history and then stands to perform the physician exam. As the physician explains the course of treatment, the cart can again be moved and adjusted to meet the needs of the patient-physician interaction.

If a physician shares the screen with a patient, the physician must be careful to ensure that the patient can see it clearly and knows where to look. It seems basic, but a patient may not feel comfortable telling a physician the screen is too high or not in focus. With electronic health records, the screen can be incredibly busy. If a physician is showing the patient something in his or her record, the physician should clearly point to the information on the screen.

Best practices in computer-physician-patient interaction are just beginning to be explored, and computer placement and room layout is just a piece of the puzzle. Best practices for individual roles and responsibilities when entering information into an EHR are also being explored, though this area too is just in the early stages of research.

Data entry as a physician responsibility?

A physician’s responsibility to enter patient, diagnosis and treatment information into an EHR is increasingly being questioned. Many physicians are starting to say they feel like data entry clerks, and they don’t want that role. For older physicians who may have never used a computer prior to EHRs being introduced into their practice, their entering information may not be very efficient.

As a result, various models of staff and technology are starting to emerge around EHR data entry. In some practices, data entry is divided among a medical assistant or nurse and the physician. Standard, commonly repetitive information, such as basic medical history items, may be entered using native EHR tools such as templates. For more complex and more unique information, such as complicated histories of present illness and psycho-social histories, voice recognition combined with the use of native EHR tools can improve efficiency and accuracy. Additionally, voice recognition “commands” can be used to speed up routine ordering within the EHR.

In other models of data capture, nurses or even non-clinician scribes may be used in various combinations. For example, the physician and assistant each with their own device may both be in the exam room with the patient. The assistant enters new information into the EHR, while the physician uses the computer primarily to view information while remaining focused on the patient-physician interaction. When the physician leaves the exam room, the assistant can remain to review and answer questions about the care plan.

Whatever model you decide upon, it’s likely to be a team effort. But, don’t make the mistake of just “letting it happen.” It’s important to delineate what data the physician will be responsible for, versus the nurse, versus the medical assistant. In the future, I expect that the patient will routinely enter a great deal of this information securely before he or she enters the exam room. In fact, this is something we’re already exploring at Mercy. The growing popularity of tablet computers and touch screen technology will likely accelerate the evolution of data capture and review.

While we don’t yet know for certain the absolute best practices for interacting with patients and computers at the same time, we are beginning to understand the impact this interaction has on patient experience and are accordingly working to better understand how to improve this interaction. As I look to the future, the challenge will not be about ensuring physicians have computer skills—something we struggled with in the past. Instead, the physicians of tomorrow—medical school students and residents today—are already absolute wizards with technology. The challenge will be how to best use the equipment we have to foster excellent interactions and relationships with patients.

Kenneth Bertka, MD, is a family physician and vice president of physician clinical integration at Mercy, a seven-hospital and physician group system based in Toledo, Ohio. Mercy is a member of Catholic Health Partners, the largest healthcare system in Ohio.
100 Hospital and Health System CIOs to Know

Becker's Hospital Review has named “100 Hospital and Health System CIOs to Know” based on leaders’ experience in healthcare and information technology. This list includes CIOs and leaders of health information technology and information services programs who are essential members to their hospital and/or health system’s executive team. These men and women have demonstrated exemplary commitment to the pursuit of innovative health technology and IT programs as a means to achieving coordinated care delivery that is of higher quality.

Note: This list is not an endorsement of included hospitals, health systems or associated healthcare providers, and organizations cannot pay for inclusion on this list. Hospital and health system CIOs are presented in alphabetical order.

Mary Alice Annecharico, RN, MS. Senior Vice President and CIO of Henry Ford Health System (Detroit). Ms. Annecharico was appointed to her current position at Henry Ford Health System in December 2011. She previously served as CIO at University of Pennsylvania School of Medicine in Philadelphia and University Hospitals in Cleveland. Ms. Annecharico also serves as editor for the peer-reviewed Journal of Health Information Management.

Pamela Arora. Vice President and CIO of Children's Medical Center Dallas. Before assuming her duties as vice president and CIO of Children's Medical Center Dallas, Ms. Arora served as CIO of Worcester, Mass.-based UMass Memorial Health Care and Perot Systems, an information technology service provider that was acquired by Dell in 2009.

Daniel Barchi. CIO of Yale-New Haven (Conn.) Health System. Mr. Barchi began his duties as CIO of Yale-New Haven Health System, which consists of three hospitals and a medical group, in 2010. Before then, he served as senior vice president and CIO of Carilion Health System in Roanoke, Va.

Mark D. Barner. Senior Vice President and CIO of Ascension Health, COO of Ascension Health Information Services (St. Louis). Along with his role as CIO of the largest Catholic health system in the country, Mr. Barner oversees Ascension Health Information Services, a wholly owned subsidiary dedicated to health information technology for the system’s 29 ministries. He previously served as CIO of Austin, Texas-based Seton Healthcare Family and oversaw government contracts with Plano, Texas-based Electronic Data Systems for 19 years.

Gary Barnes. CIO of Medical Center Health System (Odessa, Texas). Mr. Barnes serves as CIO of Medical Center Health System, which includes the 362-bed Medical Center Hospital. In addition to his career with the system, which spans more than 27 years, Mr. Barnes is currently completing his three-year term on the board of directors for the College of Healthcare Information Management Executives.

Chris Belmont. System Vice President and CIO of Ochsner Health System (New Orleans, La.). Mr. Belmont joined Ochsner Health System as assistant vice president of corporate systems in September 2006, assuming the system vice president and CIO roles in January 2009. Before these appointments, Mr. Belmont previously worked with IBM and Siemens Medical Solutions.

Scott Blanchette. Senior Vice President and CIO of Vanguard Health Systems (Nashville, Tenn.). Mr. Blanchette assumed his responsibilities with Vanguard Health Systems in May 2011. Before then, he served as vice president of product development and CIO of Franklin, Tenn.-based Healthways. Mr. Blanchette has served as staff assistant at the National Infrastructure Advisory Council to Presidents George W. Bush and Barack Obama.

Barry Blumenfeld, MD. CIO of MaineHealth and Maine Medical Center (Portland). Dr. Blumenfeld is an internist with formal training and more than 20 years of experience in health information technology design, development and implementation. He formerly served as general manager of solutions architecture for GE Healthcare Integrated IT Solutions.

Aurelia G. Boyer, RN, MBA. Senior Vice President and CIO of NewYork-Presbyterian Hospital and Health System. Ms. Boyer joined NewYork-Presbyterian Hospital in 1993 as a project manager for clinical information systems. She was promoted to director in 1996 and to vice president in 1998 before assuming her current role as CIO in 2003. Prior to her time at NewYork-Presbyterian, Ms. Boyer was a senior manager with a New York City-based healthcare information system consulting firm, Healthcare Management Counselor. She has also worked in healthcare consulting for PwC.

David Bradshaw. Chief Information, Planning and Marketing Officer of Memorial Hermann Healthcare (Houston). Mr. Bradshaw’s career with 11-hospital Memorial Hermann Healthcare dates back to 1997, when he joined the system as CIO. Before then, he spent 13 years with IBM. Memorial Hermann was named one of the Most Wired hospitals in the country by Hospitals & Health Networks for the eighth consecutive year in 2012.

Arlyn Broekhuis. Vice President and CIO of Sanford Health (Fargo, N.D. and Sioux Falls, S.D.). Mr. Broekhuis joined Sanford Health in 1982 and has held various positions in information technology throughout the past 29 years. He currently oversees an IT department that includes more than 600 employees and an annual budget of $100 million. Under Mr. Broekhuis’ tenure, Sanford Health was named a Most Wired hospital in...
Lee Carmen. Associate Vice President of Information Technology and CIO of University of Iowa Hospitals & Clinics (Iowa City). Mr. Carmen has managed information technology at academic medical centers for more than 15 years. Along with his roles as associate vice president of IT and CIO, Mr. Carmen is an adjunct faculty member at the University of Iowa School of Public Health.

Terry Carroll, PhD. Senior Vice President for Transformation and CIO of Fairview Health Services (Minneapolis). Before he joined Fairview Health Services in 2008, Dr. Carroll worked with Maverick Health Care Consulting. He previously served as COO of Premier Sourcing Partners, vice president and CIO of Detroit Medical Center, and vice president of information services and CIO of Baystate Health Systems in Springfield, Mass.

Kari Cassel. Senior Vice President and CIO of UF&Shands (Gainsville, Fla.). Ms. Cassel joined UF&Shands as CIO in 2010. In her role, she oversees information technology for UF Health Science Center and Shands at the University of Florida, the organization’s teaching hospital. Prior to her current position, Ms. Cassel served as CIO at the University of Arkansas for Medical Sciences in Little Rock and held various director of IT roles with Loma Linda (Calif.) University Medical Center.

Kumar Chatani. Senior Vice President for Information Technology and CIO of Mount Sinai Hospital (New York City). Mr. Chatani brings more than 30 years of experience to his role as senior vice president for information and CIO of Mount Sinai. He previously served as CIO for the northwest region of Kaiser Permanente in Oakland, Calif., since 2003. There, he led the development of IT systems for two major hospitals and more than 1,000 physicians.

Ken Chatfield. CIO of Health Management Associates (Naples, Fla.). As CIO of Health Management Associates, Mr. Chatfield leads the corporate information technology department, which oversees product development, software and hardware engineering, as well as technical integration and operations activities. Prior to HMA, Mr. Chatfield held several senior management positions with leading technology companies, such as Western Digital and Versata Software.

Charles Christian. CIO of Good Samaritan Hospital (Vincennes, Ind.). Mr. Christian has been serving as CIO of Good Samaritan Hospital for more than 20 years. During his tenure, Good Samaritan was named a Most Wired Hospital by Hospitals & Health Networks in 2004 and 2005. Prior to his current role, he worked in healthcare information technology for Compucare and Baxter Travenol, in management and implementation roles. Mr. Christian is a fellow of HIMSS and past chair of the board of directors.

George Conklín. Senior Vice President and CIO of Christus Health (Irving, Texas). Mr. Conklín has served as senior vice president and CIO of Christus Health since the system’s formation in 1999. He was responsible for merging the operations of two delivery systems, integrating technical operations and consolidating information to a single standards-based set for the entire system.

Randi Cox. Senior Vice President and CIO of Saint Thomas Health (Nashville). Ms. Cox has served Saint Thomas Health as senior vice president and CIO since March 2011. He previously held CIO roles with Lutheran Health Network in Fort Wayne, Ind., Riverview Hospital in Noblesville, Ind., and Richard L. Roudebush VA Medical Center in Indianapolis.

Drexl DeFord. CIO of Steward Health Care System (Boston). Prior to serving as CIO of Steward Health Care System, Mr. DeFord served as senior vice president and CIO of Seattle Children’s Health System and Research Institute. Before then, he served as corporate vice president and CIO of Scripps Health in San Diego. Mr. DeFord is currently chair of the board of trustees for the College of Healthcare Information Management Executives.

Jocelyn G. DeWitt, PhD. Vice President and CIO of University of Wisconsin Health (Madison). Ms. DeWitt has served as vice president and CIO of UW Health since April 2012. Ms. DeWitt’s accomplishments include developing strategy and funding a $300 million, seven-year electronic health record implementation. Prior to this position, Ms. DeWitt served as CIO of the University of Michigan Hospitals and Health Centers.

Daniel Drawbaugh. Senior Vice President and CIO of University of Pittsburgh Medical Center. Mr. Drawbaugh has served as senior vice president and CIO of University Pittsburgh Medical Center since 1996. He has led the medical center in developing an extensive system for collecting and exchanging electronic medical records across all systems. Prior to serving with UPMC, he spent time at Pittsburgh-based Shadyside Hospital, now UPMC Shadyside, as director of biomedical engineering.

Darren Dworkin. Senior Vice President of Enterprise Information Systems and CIO of Cedars-Sinai Health System (Los Angeles). Mr. Dworkin has served as senior vice president of enterprise information systems and CIO of Cedars-Sinai Health System since 2006. He has more than 20 years of experience in information technology and more than 12 years of experience in healthcare. Prior to joining Cedars-Sinai, Mr. Dworkin held the position of chief technology officer at Boston University Medical Center.

Philip Fasano. Executive Vice President and CIO of Kaiser Permanente (Oakland, California). Mr. Fasano has served as executive vice president and CIO of Kaiser Permanente since 2009. Mr. Fasano has been a leader in the integration of technology and care delivery, and he has been instrumental in the organization’s transition to a fully integrated electronic health record system.

Lee W. Fine. CIO of Sentara Healthcare (Norfolk, Va.). Mr. Fine has served as CIO of Sentara Healthcare since 2008. He has led the strategic planning and implementation of the organization’s electronic health record system, which serves more than 20 hospitals and health centers in the region.

Mary Byerly. CIO of Stanford Hospital & Clinics (Palo Alto, Calif.). Ms. Byerly was named CIO of Stanford Hospital & Clinics in May 2013. Prior to joining Stanford, she served as CIO of the University of Michigan Hospitals & Health Networks.

Samantha Carter. CIO of Sharp HealthCare (San Diego). Mr. Carter has served as CIO of Sharp HealthCare since 2011. Prior to joining Sharp, he served as CIO of UC San Diego Health System.

Ken G. Chatfield. CIO of Aetna Inc. (Newington, Conn.). Mr. Chatfield has served as CIO of Aetna Inc. since 2004. He has led the organization’s efforts to modernize its IT infrastructure and improve its customer experience.

James Chastain. CIO of Sutter Health (Sacramento). Mr. Chastain has served as CIO of Sutter Health since 2007. He has led the organization’s efforts to modernize its IT infrastructure and improve its customer experience.

Philip C. Christensen. CIO of Advocate Health Care (Oak Park, Ill.). Mr. Christensen has served as CIO of Advocate Health Care since 2003. He has led the organization’s efforts to modernize its IT infrastructure and improve its customer experience.

Samantha Carter. CIO of Sharp HealthCare (San Diego). Mr. Carter has served as CIO of Sharp HealthCare since 2011. Prior to joining Sharp, he served as CIO of UC San Diego Health System.

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Philip C. Christensen. CIO of Advocate Health Care (Oak Park, Ill.). Mr. Christensen has served as CIO of Advocate Health Care since 2003. He has led the organization’s efforts to modernize its IT infrastructure and improve its customer experience.
As executive vice president and CIO of Kaiser Permanente, a role he has held since 2007, Mr. Fasano oversees IT for one of the nation’s largest non-profit health plans and healthcare providers. Under his leadership, the company has created tools and platforms to deliver smarter, more connected care. Mr. Fasano was nationally recognized as one of Computerworld’s “Premier 100 IT Leaders” in 2010.

James S. Fine, MD. CIO of University of Washington Medical Center (Seattle). As CIO of UW Medicine, a role he has held since July 2005, Dr. Fine oversees IT for several entities, including University of Washington Medical Center and School of Medicine, UW Neighborhood Clinics and UW Physicians. He is a board-certified clinical pathologist with expertise in information technology, evidenced in the initiatives he has led for UW Medicine, such as the implementation of a clinical information system in 2008.

John Foley, CIO of University Hospitals (Cleveland). Mr. Foley was appointed CIO of University Hospitals in August 2012. Prior to this appointment, he served as CIO of West Penn Allegheny Health System in Pittsburgh from 2008 to February 2012. Mr. Foley has also served with information security companies during his career in information technology.

Randall Gaboriault, Vice President of Information Technology and CIO of Christiana Care Health System (Wilmington, Del.). Mr. Gaboriault joined Christiana Care Health System in 2010 as vice president and CIO. Mr. Gaboriault also serves as chair of the information technology task force for the Delaware Health Science Alliance. Previously, he served Teleflex Inc., a multi-billion dollar medical device company in Limerick, Pa., as senior vice president, CIO and strategic development officer.

Indranil Ganguly, Vice President and CIO of CentraState Healthcare System (Freehold Township, N.J.). Mr. Ganguly joined CentraState in 1999. Since then, the health system has been named a Most Wired hospital by Hospitals & Health Networks three times — in 2010, 2011 and 2012. Prior to his current role, Mr. Ganguly served Elizabeth (N.J.) Medical Center as a project leader and acting director, where he led numerous information technology projects.

Dave Garrett, Senior Vice President and CIO of Novant Health (Winston-Salem, N.C.). Mr. Garrett joined Novant Health in 2008 as senior vice president and CIO. Mr. Garrett brings more than 37 years of information technology experience in banking, hospitality and healthcare to the planning and execution of corporate information technologies and telecommunications at Novant Health.

Art Glasgow, CIO of Duke Medicine (Durham, N.C.). Mr. Glasgow began serving as CIO of Duke Medicine in May 2011. Previously, he served as chief technology officer for Ingenix, an informatics company that supports UnitedHealthcare and other clients. There, he led a team of more than 1,500 employees and managed an annual budget of $300 million. Prior to his role with Ingenix, Mr. Glasgow held senior leadership positions with nationally recognized electronic medical record vendors and innovative IT start-up companies.

Joy Grosser, Vice President and CIO of Iowa Health System (West Des Moines). Ms. Grosser became vice president and CIO of Iowa Health System in 2009. Before then, she served as CIO for the University of California-Irvine Health Sciences System. She also worked for Loyola University Health System in Maywood, Ill., and Research Medical Center in Kansas City, Mo.

John Halamka, MD. CIO of Beth Israel Deaconess Medical Center (Boston). Dr. Halamka began serving as CIO of Beth Israel Deaconess Medical Center in 1998. He also served as CIO of Harvard Medical School from...

C. Martin Harris, MD, MBA. CIO of Cleveland Clinic. Dr. Harris joined Cleveland Clinic in 1996. He is a member of HHS’ Health Information Technology Standards Committee and, in 2007, received an appointment to the Commission on Care for America’s Wounded Warriors, a bipartisan presidential commission. Dr. Harris is past chairman of the Healthcare Information and Management Systems Society and has also served on HHS’ Board of Regents of the National Library of Medicine.

Donette Herring. Vice President and CIO of Catholic Health East (Newtown Square, Pa.). Ms. Herring serves as vice president of information technology and CIO for Catholic Health East. She joined CHE in August 2004 as vice president of information technology shared services. Prior to this, she served as CIO of Catholic Health Services of Long Island in Rockville Centre, N.Y., as CIO of the eastern region of Catholic Health Initiatives in Englewood, Colo., and as director of information systems for Franciscan Health System before it merged to form CHI.

Steve Hess. CIO of University of Colorado Health (Aurora). Mr. Hess was named CIO of University of Colorado Health in 2012. UCHealth is a new, Colorado-based healthcare system that includes five hospitals and dozens of clinics throughout Colorado, Wyoming and western Nebraska. Mr. Hess was previously CIO of University of Colorado Hospital in Aurora from 2009 to 2012. Prior to that, he served as CIO of Christiana Care Health System in Wilmington, Del., for five years.

George T. Hickman. Executive Vice President and CIO of Albany (N.Y.). Medical Center. Mr. Hickman is executive vice president and CIO of Albany Medical Center, which is his third academic CIO post. He has worked within health provider organizations across the United States as well as for the Ministry of Health in Singapore and the United Kingdom. He previously served as board chair and executive compensation committee chair for the Healthcare Information and Management Systems Society.

Gilbert Hoffman. Vice President and CIO of Mercy (Chesterfield, Mo.). Mr. Hoffman was named vice president and CIO of Mercy in October and began serving in November. Prior to this role, he worked at Maritz, a St. Louis-based travel company, since 1973. Mr. Hoffman was named one of the top 100 CIOs in the nation by ComputerWorld in 2007.

Ross Hurd. CIO of Lake Chelan Community Hospital (Chelan, Wash.). Mr. Hurd has led Lake Chelan Community Hospital as CIO since 2006. Under his leadership, the hospital has implemented telepharmacy, teleradiology and telestroke programs, along with telehealth education. Under Mr. Hurd’s guidance, the hospital was recognized in the small and rural hospitals category for Hospitals & Health Networks 2010 and 2011 Most Wired surveys.

Keith Jennings. CIO of Massachusetts General Hospital (Boston). Keith Jennings began serving as CIO of Massachusetts General Hospital and Massachusetts General Physicians Organization in September 2012. Mr. Jennings has served the hospital for 10 years, and served as interim director of information services management and planning. Prior to his career with Massachusetts General, Mr. Jennings spent 10 years in information services for other healthcare organizations, and as a military police officer and civil affairs officer in the U.S. Army Reserve.

Dan Kinsella. Executive Vice President and CIO of Cadence Health (Winfield, Ill.). Before joining Cadence Health in 2012, Mr. Kinsella served as a senior vice president at Optum Insight, a division of UnitedHealthcare. There, he led technology consulting within the division’s accountable care services practice.

Arthur J. Krumrey. Vice President and CIO of Loyola University Health System (Maywood, Ill.). Mr. Krumrey has served Loyola University Health System in an information technology function for more than 20 years. He began his role as vice president and CIO of the system in July 2012. Before then, he served as vice president and CIO of Loyola University Medical Center since 2002.

Richard D. Lang, EdD, PMP. Vice President and CIO of Doylestown Hospital (Bucks, Pa.). Dr. Lang was named CIO of Doylestown Hospital in 2006 after 25 years of experience in healthcare-related information technology. Prior to this appointment, he served as a principle in knowledge related information technology. Prior to this appointment, he served as a principle in knowledge and technology integration services for the consulting firm Know-Power and as vice president of information services for Holy Redeemer Health System in Meadowbrook, Pa. Dr. Lang is currently serving a three-year term on the national board of directors for the Healthcare Information and Management Systems Society, which began in 2011.

Tom Langston. Senior Vice President and CIO of SSM Health Care (St. Louis). Mr. Langston serves as senior vice president and CIO of SSM Health Care. He is also a senior leader for SSM Integrated Health Technologies, an SSM Health Care business unit responsible for information technology and clinical engineering services at SSM’s acute-care hospitals, physician practices and nursing homes. In 2001, Mr. Langston became the first president of SSM Information Center and later SSM Integrated Health Technologies.

Brian Loflin. CIO of IASIS Healthcare (Franklin, Tenn.). As CIO of IASIS Healthcare, a position he has held since 2004, Mr. Loflin oversees all of the information technology operations for the company’s 16 hospitals and more than 10,000 employees. Prior to serving as CIO, he served as manager of information systems operations and director of information systems for IASIS.

Philip Loftus, PhD. CIO of Aurora Health Care (Milwaukee). Mr. Loftus has served as vice president and CIO of Aurora Health Care since 2006. He provides an integrated approach to healthcare delivery by defining and implementing the information technology component of Aurora’s strategic mission. Before serving Aurora Health, Mr. Langston served as senior vice president and CIO of Caremark.

Jackie Lucas. Vice President and CIO of Baptist Healthcare System (Louisville, Ky.). As vice president and CIO of Baptist Healthcare, Ms. Lucas oversees IT for seven hospitals, ambulatory services and the system’s health plan. Prior to becoming CIO, she held director positions in IT and telecommunications at Baptist Healthcare and LeBonheur Health System in Memphis, Tenn. She was recognized in 2012 as a “Premier 100 IT Leader” by ComputerWorld.

Jonathan Manis. CIO of Sutter Health (Sacramento, Calif.). Mr. Manis has served Sutter Health as CIO since September 2006, after he left Urbana, Ill.-based Provista Health after serving five years as system vice president of administrative services and CIO. Prior to his time at Provista, he served as vice president of information services for Oakbrook, Ill.-based Advocate Health Care.

Randy McCleese. Vice President of Information Services and CIO of St. Claire Regional Medical Center (Morehead, Ky.). Before joining St. Claire Regional Medical Center as CIO, Mr. McCleese spent more than 14 years with Equitable Resources in Prestonsburg, Ky., and Kingsport, Tenn., as a geologist and manager of information resources. He has more than 23 years of information systems management experience, with 15 years devoted to healthcare.

William McConnell, Jr. Senior Vice President and CIO of Indiana University Health (Indianapolis). Mr. McConnell joined IU Health in 2012. Prior to this role, he was president and CEO of Indianapolis start-up company FlowCo. Before then, he served as vice president and CIO for Guidant Corp., part of Boston Scientific and Abbott Labs, for nine years after serving as senior vice president and CIO for Resort Condominiums International from 1990 to 1996.

Virginia A. McFerran, MS. CIO of UCLA Health System and David Geffen School of Medicine at UCLA (Los Angeles). Ms. McFerran was appointed CIO of UCLA Health System in 2009. With her leadership team, she plays a vital role in collaboratively gaining buy-in for the overall IT strategic plan and operationalizing the plan with successful implementation. Prior to joining UCLA, Ms. McFerran served...
as CIO and department head at Weill Cornell Medical College in New York City.

Bruce Metz, PhD. Senior Vice President and CIO of Lahey Clinic (Burlington, Mass.). Since joining Lahey Clinic in 2011, Dr. Metz has led an enterprise-wide strategy to grow the organization and achieve the highest levels of patient care. He came to Lahey after serving as CIO of Thomas Jefferson University in Philadelphia and its affiliated hospitals for six years.

Nader Mherabi. Senior Vice President, Vice Dean and CIO of NYU Langone Medical Center (New York City). During his 23 years in the information technology field, Mr. Mherabi has held IT management positions with Mount Sinai Hospital in New York City, Credit Suisse First Boston, Citibank and AT&T. Prior to serving as vice dean and CIO of NYU Langone Medical Center, he served the hospital as vice president for IT product solutions and chief technology officer.

Jim Murry. CIO of University of California-Irvine Medical Center. Mr. Murry has served as CIO of University of California Irvine Medical Center since 2008. Prior to serving UC Irvine, he was senior vice president and CIO of City of Hope National Cancer Center and Beckman Research Institute, both in Los Angeles, from 2006 to 2008 and vice president of IT at Kaiser Permanente in Oakland, Calif., from 2002 to 2006. Mr. Murry has been involved in electronic medical records and clinical implementations since 1984.

Michael Nelson. Vice President and CIO of Universal Health Services (King of Prussia, Pa.). As CIO, Mr. Nelson is responsible for all aspects of UHS’ information services strategy, budget, daily operations and 200-plus staff. Prior to joining UHS, he was an information services vice president for Carolinas HealthCare System in Charlotte, N.C.

Laureen O’Brien. Vice President and CIO of Providence Health & Services (Renton, Wash.). Ms. O’Brien has more than 30 years of experience in health information technology. Before joining Providence as vice president and CIO in 1997, Ms. O’Brien served as the divisional director of information services for a large integrated delivery network in Denver. At Providence, Ms. O’Brien has oversight of information service for a $10 billion, five-state non-profit healthcare ministry.

Michael O’Rourke. Senior Vice President and CIO of Catholic Health Initiatives (Englewood, Colo.). Mr. O’Rourke joined Catholic Health Initiatives as a private consultant in 2007 before accepting the permanent CIO position two years later. Mr. O’Rourke has transformed the organization’s information technology services from 45 separately functioning, individual operations into a single, consolidated national structure. He is veteran of more than 25 years in the healthcare technology field.

Marty Paslick. Senior Vice President and CIO of Hospital Corporation of America (Nashville, Tenn.). Mr. Paslick has spent more than 27 years with HCA, leading the company’s information technology and services departments as senior vice president and CIO. He was named CIO in June 2012. Prior to that, he served as COO for two years. Mr. Paslick led the development of new IT units to pursue business opportunities and the transformation of the organization’s field-based IT operations.

Marc Probst. Vice President and CIO of Intermountain Healthcare (Salt Lake City). Mr. Probst began serving Intermountain Healthcare as vice president and CIO in 2004. Before then, he was a partner with Deloitte Consulting, a partner with Ernst & Young and served as a senior manager at First Consulting Group. Mr. Probst has been a leader in health IT for the past 20 years. He is currently serving as a member of the Health Information Technology Policy Committee, a federal advisory committee to the Office of the National Coordinator for Health Information Technology.

Shafig Rab, MD. Vice President and CIO Hackensack (N.J.) University Medical Center. Dr. Rab joined HackensackUMC as CIO in March 2012. He had previously served as vice president and CIO of Greater Hudson Valley Health System in Middletown, N.Y., since 2008. Prior to his time at Greater Hudson, Dr. Rab served as vice president and CIO of St. Mary’s Hospital in Passaic, N.J.

Stephanie L. Reel, MBA. Vice President for Information Services for Johns Hopkins Medicine, Vice Provost for Information Technology and CIO for Johns Hopkins University. (Baltimore). Ms. Reel has been vice provost for information technology and CIO for Johns Hopkins University since January 1999. She also serves as vice president for information services for Johns Hopkins Medicine, a post she has held since 1994.

Michael Restuccia. Vice President and CIO of University of Pennsylvania Health System (Philadelphia). Mr. Restuccia has more than 25 years of healthcare information technology experience. Before he joined UPHS as vice president and CIO in 2008, Mr. Restuccia served as president of MedMatica Consulting Associates, and held numerous interim CIO positions at hospitals and health systems across the country.

Craig Richardville. Senior Vice President and CIO of Carolinas HealthCare System (Charlotte, N.C.). Mr. Richardville began serving as senior vice president and CIO of Carolinas in 1997. Mr. Richardville is responsible for the system’s information services strategy, technology and operations as well as support services, clinical engineering and transcription services.

Rick Rinehart. Vice President of Information Technology and CIO of Carle Foundation Hospital (Urbana, Ill.). Mr. Rinehart was appointed as vice president of information technology and CIO in December 2007. He previously served as interim CIO. Mr. Rinehart has more than 25 years experience in the technology field, with more than 10 years in senior management.

Deb Rislow. Vice President, Chief Administrator and CIO of Gundersen Lutheran Health System (La Crosse, Wis.). Ms. Rislow brings 22 years of information systems experience in healthcare-related industries to her role...
as CIO and director of information systems at Gundersen Lutheran Health System. She began this position in July 1997. Previously, she served as manager of application and technical services and was a systems analyst programmer for Gundersen Lutheran.

Cris Ross. CIO of Mayo Clinic (Rochester, Minn.). Mr. Ross came to Mayo Clinic in 2010 after serving Surescripts, where he led the company’s interoperability business as executive vice president and general manager of clinical interoperability. Prior to joining Surescripts, Mr. Ross served as CIO and then executive vice president of product and information services at MinuteClinic during a period of rapid growth, as the retail clinic expanded from 60 to 650 clinics.

Sherrie Russell. Vice President and CIO of Alexian Brothers Health System (Arlington Heights, Ill.). Ms. Russell was named vice president and CIO of the Alexian Brothers Health System in May 2011. She came to Alexian Brothers, which includes two acute-care hospitals, after more than 30 years of progressive IT experience in key executive roles where she oversaw the IT strategic planning and support for large integrated healthcare delivery networks.

Sue Schade. CIO of University of Michigan Health System (Ann Arbor). Ms. Schade assumed her responsibilities as CIO of University of Michigan Health System in November 2012. Before then, she served as CIO of Brigham and Women’s Hospital in Boston for 12 years. There, she led implementation of the Balanced Scorecard initiative, which links quality outcomes to financial data.

Joseph H. Schneider, MD. Chief Medical Information Officer and Medical Director of Baylor Health and Hospital System (Dallas). Before he joined Baylor Health and Hospital System, Dr. Schneider served as CMIO of Children’s Medical Center in Dallas. He is chairman of the Texas Medical Association Committee on Health Information Technology and was one of the original authors of the continuity of care record standard, which has since been integrated into many EMRs to exchange clinical information electronically.

J. Gary Seay. Senior Vice President and CIO of Community Health Systems (Franklin, Tenn.). Mr. Seay’s career with Community Health Systems dates back to 1997. In addition to his role with the 135-hospital operator, Mr. Seay is also an adjunct professor of management, specializing in health information technology, at Vanderbilt University in Nashville, Tenn.

Marcus B. Shipley. Senior Vice President and CIO of Trinity Health (Novi, Mich.). Mr. Shipley began his tenure as senior vice president and CIO of 47-hospital Trinity Health in April 2012. His career in information technology spans 20 years and includes several industries. Before his current appointment, he worked with health insurer Cigna as vice president of information technology, IT infrastructure and operations.

Stan Simpson. Regional CIO of Ascension Health Indiana Region and CIO of St. Vincent Health (Indianapolis). Mr. Simpson joined St. Vincent Health in 2007. He previously held leadership positions with a variety of health systems, including Provenant Health Partners in Grandby, Colo.; Sutter Health in Sacramento, Calif.; and Carle Foundation Hospital in Urbana, Ill.

Alan Smith. Vice President and CIO of Capella Healthcare (Brentwood, Tenn.). Mr. Smith was appointed vice president and CIO of Capella Healthcare in April 2011. Before then, he served as vice president of applications for Nashville, Tenn.-based Vanguard Health Systems. He also spent time with Carolinas Healthcare System in Charlotte, N.C., as vice president of clinical applications.

Bruce Smith. Senior Vice President of Information Systems and CIO of Advocate Health System (Oakbrook, Ill.). Before serving as senior vice president of information systems and CIO of Advocate Health, Mr. Smith was vice president and CIO for Advocate Lutheran General Health System. He is a member of HIMSS, HIMSS’ Chicago CIO Roundtable and the Scottsdale Institute, a healthcare executive resource for information management.

Steven Smith. CIO of NorthShore University Health System (Evanston, Ill.). Mr. Smith was named CIO of four-hospital NorthShore University Health System in April 2012. Previously, he spent 11 years as chief technology officer and 18 years traveling the country as a health IT systems outsourcer for the health system. Mr. Smith oversaw NorthShore’s integrated EMR system implementation, and in 2009, NorthShore was among the first systems to receive recognition from HIMSS Analytics for stage 7 status.

Brent G. Snyder, Esq. CIO of Adventist Health System (Winter Park, Fla.). Before he assumed his duties as CIO of Adventist Health System, Mr. Snyder served as CFO of the system’s Multi-State Division for roughly five years.

He formerly served as vice president and CFO of Tennessee Christian Medical Center in Madison, Tenn., and CFO of Takoma Adventist Hospital in Greeneville, Tenn.

Alan Soderblom. Vice President and CIO of Adventist Health (Roseville, Calif.). Mr. Soderblom began his tenure as vice president and CIO of 19-hospital Adventist Health in June 2007. Mr. Soderblom led Adventist’s recent initiative to expand its EMR to more than 130 outpatient clinics in four states.

Subra Sripada. Executive Vice President, Chief Administrator and Information Officer of Beaumont Health System (Royal Oak, Mich.). Mr. Sripada serves as executive vice president and CIO of Beaumont Health, which consists of nine hospitals. Mr. Sripada joined Beaumont in November 2008 after serving in a leadership role at PwC. He also worked for six years at Henry Ford Health System in Detroit.

William Stead, MD. CIO of Vanderbilt University Medical Center (Nashville, Tenn.). In addition to his role as CIO of Vanderbilt University Medical Center, Dr. Stead serves as the McKesson Foundation Professor of Biomedical Informatics, professor of medicine and chief strategy officer at Vanderbilt. Dr. Stead, who has worked at the crossroads of informatics and clinical practice for 40 years, established the department of medical informatics and led the development of information management infrastructure at Vanderbilt throughout the past 20 years.

Rebecca Sykes. Senior Vice President, Resource Management and CIO of Catholic Health Partners (Cincinnati). Ms. Sykes assumed her current role in 1999 after serving as Catholic Health Partners’ director of corporate information services. Resource management was added to her title in July 2011, as Catholic East Partners implemented new systemwide efforts to operate profitability within Medicare’s payment structure. Prior to joining the system, Ms. Sykes was director of information systems for TriHealth in Cincinnati.

Phyllis Teater, MBA. Associate Vice President of Health Sciences and CIO of The Becker’s Hospital Review Annual Meeting
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Ohio State University Wexner Medical Center (Columbus). Ms. Teater was named CIO of The Ohio State University Wexner Medical Center in October 2010 after serving as the hospital’s interim CIO for roughly 10 months. Ms. Teater, who joined the hospital in 1991, has also testified before the House Committee on Ways & Means on the adoption of meaningful use.

Gretchen Tegethoff. CIO of Athens (Ga.) Regional Medical Center. Ms. Tegethoff has been CIO of 364-bed Athens Regional Medical Center since February 2012. Before then, she served as CIO of George Washington Hospital Center since 2009. She also has served as CIO of Athens Regional Medical Center.

Tim Thompson. CIO of BayCare Health System (Clearwater, Fla.). Mr. Thompson assumed his duties as CIO of BayCare Health in September 2010. Before then, Mr. Thompson served as senior vice president and CIO of Methodist Hospital System in Houston. He also spent time as senior vice president and CIO of Adventist Health System in Winter Park, Fla., and Palmetto Health in Columbia, S.C.

Stephen Tranquillo. Vice President and CIO for Thomas Jefferson Hospital (Philadelphia). Mr. Tranquillo became vice president and CIO of Thomas Jefferson Hospital in November 1999. Before then, he served as director of information systems at the hospital for about four years. Mr. Tranquillo also served as vice president of Hebrew Health System in Sewell, N.J., as clinical information systems manager.

Sean Tuley. Senior Vice President and CIO of LifePoint Hospitals. (Brentwood, Tenn.). Mr. Tuley was appointed senior vice president and CIO of LifePoint Hospitals, which includes more than 50 hospital campuses, in January 2010. Before then, he served as vice president of provider services for Emdeon Business Services, a revenue and payment cycle solution firm, and as COO of the Physician Services Division of Perot Systems, an information technology provider.

Alex Vaillancourt. Vice President and CIO of The Christ Hospital (Cincinnati). Mr. Vaillancourt was named CIO of The Christ Hospital in February 2011. Prior to joining the hospital in 2008 as director of solutions architecture, Mr. Vaillancourt served as director of information technology at McCullough-Hyde Memorial Hospital in Oxford, Ohio. The Christ Hospital was named one of the Most Wired hospitals in the country in 2012 by Hospitals & Health Networks.

Lac Van Tran. Senior Vice President of Information Services, Associate Dean of Information Technology and CIO of Rush University Medical Center (Chicago). Mr. Van Tran has held his current post at 644-bed Rush University Medical Center since November 2002. Before then, he served as senior vice president and CIO of Methodist Hospital System in Houston, vice president and CIO of Children’s Hospital Boston and CIO of Stony Brook (N.Y.) Medical Center.

Jim Veline. Senior Vice President and CIO of Avera Health (Sioux Falls, S.D.). As senior vice president and CIO of Avera Health, Mr. Veline has led the five-hospital system to garner 13 Most Wired awards. Furthermore, in 2012, the system’s eEmergency service was recognized with a “Most Wired Innovator Award” from Hospitals & Health Networks.

Joel Vengco. Vice President of Information Services and CIO of Baystate Health (Springfield, Mass.). As vice president of information services and CIO, Mr. Vengco oversees the technology strategy and operations for Baystate Health’s four hospitals. Before his current role, Mr. Vengco was vice president and general manager of one of the four global businesses that comprise GE Healthcare. Earlier in his career, Mr. Vengco was a senior medical informaticist at Partners HealthCare in Boston.

Lynn H. Vogel, PhD. Vice President and CIO of University of Texas MD Anderson Cancer Center (Houston). Along with his duties as vice president and CIO of MD Anderson Cancer Center, Dr. Vogel holds an appointment as associate professor of bioinformatics and computational biology at the teaching hospital. He also carries an adjunct professor appointment in management at University of Texas School of Public Health.

Jerry Vuchak. Vice President of Information Systems of Barnes-Jewish Hospital (St. Louis). Mr. Vuchak joined Barnes-Jewish Hospital as vice president of information systems in April 2007. He was promoted to vice president of information services, academic hospitals and the Washington University School of Medicine’s integration with Barnes-Jewish in August 2008. In that role, Mr. Vuchak oversaw IT alignment between Barnes-Jewish hospitals and the medical school. He has 25 years of experience in the information technology field.

Michael S. Warden. Senior Vice President and CIO of Banner Health (Phoenix). Mr. Warden joined Banner Health as senior vice president of information technology and CIO in 1998, when the system operated as Samaritan Health System. Before then, Mr. Warden served as vice president of information and CIO for Memorial Hermann Healthcare System in Houston.

Laishy Williams-Carlson. Vice President and CIO of Bon Secours Health System (Richmond, Va.). Ms. Williams-Carlson has served as vice president and CIO of Bon Secours Health System since 2006. Before then, she served as vice president and CIO of Bon Secours Hampton Roads Health System in Norfolk, Va., for nine years.

Deanna Wise. Executive Vice President and CIO of Dignity Health (San Francisco). As executive vice president and CIO, Ms. Wise oversees all of Dignity Health’s information technology functions with a focus on the 40-hospital system’s electronic medical records. Before assuming her current position in November 2011, Ms. Wise served as senior vice president and CIO of Nashville, Tenn.-based Vanguard Health Systems.

Eric Yablonka. Vice President and CIO of University of Chicago Medicine. Mr. Yablonka began his tenure as vice president and CIO of University of Chicago Medicine in August 2001. Before then, he served as vice president and CIO of Saint Raphael Healthcare System in New Haven, Conn. ■

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A sports analogy: In football, there are no mysterious schemes or strategies that can’t be examined and understood. More often than not, between two well-coached teams, the one with better blockers, tacklers and players with the talent to execute, will win. Successful hospitals do not have exclusive access to secret software products or strategies. They have more leaders, physicians and staff who can adapt, innovate, work in teams, solve difficult problems, perform and deploy proven strategies and technologies. It really is just this simple.

The difference between success and failure

Research, data and observation confirm it. Successful organizations have teams that display certain behaviors. Organizations that are able to find, hire, develop and retain people who can perform, succeed. Those that don’t, struggle. When programs fail, it is because key individuals fail to demonstrate critical behaviors.

Why does a hospital struggle to eliminate central line infections even though it adopts identical protocols proven successful at another hospital? Is it a lack of software or the group’s technical skills or knowledge? No. The failure is that people on the team do not have the ability to collaborate, to manage the people involved, to adapt, to innovate, to handle pressure, and to influence others. Same problem, same facts, same situation, but different people. The relevant variable is talent.

Talent as a top priority

Does your organization dedicate sufficient time, energy and resources to building the team? Healthcare, generally, is woefully behind the rest of the world when it comes to using deliberate talent strategies. Think again about our football analogy. Winning teams commit resources to finding and developing talent — all year round. Scouts scout the college ranks. Teams know with great specificity what attributes they are seeking. Strengths are leveraged and weaknesses addressed. Players are put in positions where they have the best chance to succeed. Players that develop stay and progress. Those that don’t are replaced. Nothing is more important to a winning program than its approach to talent, and it is reflected in its priorities. In many hospitals, human resources is still thought of as an administrative function. It’s only recently that some hospitals have given HR a seat at the senior leadership table.

Talent strategies of successful organizations

1. Define the behaviors that will drive your culture. Most hospitals spend a fair amount of energy developing vision and mission statements, and then a list of values. The challenge is in “operationalizing” these values. How do you link every job to these values? How does a physician, a nurse, a manager or a transporter, demonstrate, for instance, teamwork, collaboration, adaptability, caring or integrity?

   The culture of your organization is not defined by the values on your website. It is defined by the behaviors of individuals, and the behaviors that are reinforced and displayed in the workforce, as a whole. This requires work one level below defining values — defining specific behaviors that are to be expected — and that leads to the outcomes you desire.

   Successful organizations define the specific behaviors at each level of the organization that will lead to, for instance, patient-centered care. A word of caution: As important as this is, it’s an endeavor that can very easily become all consuming and grow to be unwieldy. That being said, how can you have a patient-centered culture if you have not defined what patient-centric behaviors you expect from physicians or nurses or senior leaders?

2. Select better leaders — at all levels. Successful organizations identify and develop individuals with leadership potential. This is a relatively new concept for hospitals. Traditionally, a physician who is vocal, productive, influential and perhaps academically prolific rises to a leadership position. It’s been common to make our best nurse a nurse-manager. This in spite of the fact that success as a clinician not only does not ensure success as a leader, but traditional healthcare training and development often discourage the sort of collaboration, adaptability and servant leadership that is needed today.

   Rarely was serious thought given to understanding the behavioral competencies that predict success in a leadership role in the organization. Even less common has been an attempt to objectively evaluate those competencies either for promotion or as the basis of a developmental plan. Fortunately, more hospitals and systems are now committing resources to identifying and developing leaders. They use their performance management program to identify those with leadership potential and use structured leadership development to build their next class of leaders.

   Hospitals have been particularly slow to adopt executive level selection strategies used by other industries. The vast majority of medium to large sized companies use some form of structured executive assessment process to select senior leaders. By contrast, even in a time when we are asking more of leaders, many healthcare organizations have ignored succession planning and still make placement decisions based on nothing but intuition.

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Organizations improve the return on their most important investment – their people. The research, and more importantly the empirical evidence from other industries, is conclusive. By adding objective measures to the selection process, you significantly increase the odds of making the right decision. Other industries, for decades, have used scientific and structured selection strategies to improve customer satisfaction, productivity, quality and profitability. Leading hospitals are adopting these strategies.

Technical skills are rarely the reason for performance failures. Performance issues turn on behaviors. The traditional approach to sourcing and screening candidates is wholly inadequate at evaluating these behaviors. For example, it’s been shown that the traditional candidate interview, be it for a physician, nurse or tech, has no predictive value. Yet we continue the process. Step one is to design and implement a consistent, behaviorally based, structured interview process to glean useful information and ensure you are evaluating patient-centered competencies.

There also now exist easy to use and user-friendly tests and assessments for various healthcare positions. These may serve to eliminate candidates who clearly don’t fit your culture, or to differentiate between candidates who look similar on paper. Combined with a well-designed interview program, these assessments add significantly to the predictive nature of your selection system. You will increase the odds that those you bring into the organization have the requisite behavioral skills.

4. Coordinate all talent functions. It is not uncommon that there are different sets of competencies and priorities between what should be coordinated and consistent HR functions. Selection, training, performance management and succession planning are handled by different departments that don’t necessarily communicate and may even be working from multiple behavioral competency models designed specifically for each department.

Successful hospitals work from a single behavioral competency model, designed for use across all HR functions. In this manner, the behavioral competencies form the foundation for all related functions and for the organizational culture.

5. Look at the entire organization. A change in organizational culture doesn’t occur because of work at one level of the organization. An example: You may hire front-line nurses who are patient-centered high performers, ready to innovate and adapt. High performers need to be supported, and the single most influential factor in turnover is the relationship with the direct supervisor. If you neglect, then, to find managers ready to lead them, you will have little impact on the culture and likely lose many of these wonderful new nurses.

Don’t overlook the importance of “lower” level positions. While nurses make up 30 percent of your workforce, front-line workers including dietary, environmental services and transporters, make up a significant portion of the people who influence the experience of patients and their families. While these positions are easier to fill and have lower per employee labor costs, high turnover is costly and has a negative impact on patients. Finally, don’t exclude physicians from this thought process. We are expecting more of physicians as partners in crafting patient-centered, high value care models. You need physicians who have the behavioral skills to help the organization succeed. With the growing trend of physician employment by hospitals, we are creating a very unique physician “workforce” that needs to be built, managed and developed with the future in mind.

6. Enhance the effectiveness of patient satisfaction training; incorporate healthcare EQ. The current approach to patient satisfaction-based training is to give everyone the same program and hope for the best. This approach is the equivalent of a cardiologist treating every patient who walks into his or her office with the same diet, same exercise prescription and same medication, regardless of the patient’s diagnosis.

Just like every patient with a heart condition is different, each staff member brings a different psychological and behavioral make-up to the patient interaction. Each has different strengths and weaknesses. Until each staff member understands these strengths and weaknesses, and develops strategies to improve how they address patient’s needs, real change will remain elusive.

There is a renewed interest in healthcare, in emotional intelligence, a concept popular in other industries since the 1990s. Healthcare has been slow to adopt, partially because of a lack of early evidence of its effectiveness, and partially because the traditional construct of EQ does not quite fit the unique nature of healthcare. Recently though, the idea of healthcare-specific EQ is proving more relevant. EQ is a complicated concept to begin with and applying it to the idea of patient-centered care requires an understanding of how EQ in this setting differs from traditional EQ. For instance, empathy (a traditional component of EQ) must be understood within the context of the provider-patient relationship and scoring too high on empathy may be problematic.

More importantly, there is evidence that some components of HEQ can improve with training. Rather than blanket training staff on a checklist of actions that will, hopefully, improve the patient experience, progressive organizations are providing staff with insight into their own behavioral DNA via a measure of HEQ. Just as talent selection strategies are focusing on the behavioral competencies of the individual, patient-satisfaction training can target specific behaviors of each individual staff member.

Since its founding in 1993, Select International has been dedicated to developing assessment solutions that help companies identify, select and develop top talent throughout their organization. Select’s Healthcare Solutions Group specializes in developing assessment technology to help healthcare organizations improve the return on their most important investment – their people.
How Has the Rise of Physician Employment Changed Hospitals’ Recruitment Strategies?

By Molly Gamble

The appeal of hospital employment to physicians is no secret. Upon completion of their training, more physicians are looking to work in either larger, independent group or hospital-owned practices, whether for financial reasons, lifestyle preferences or a combination of the two. The number of independent physicians, or providers with a financial stake in their practice, shrank from 57 percent in 2000 to 39 percent in 2012 and a projected 36 percent in 2013, according to data from Accenture.

In the latest annual Residents and Fellows Survey conducted by Cejka Search, 46 percent of respondents from medical schools’ 2012 graduating classes said group practices were the ideal choices, while 29 percent said hospital-affiliated practices were most preferred. And interest in employed physicians also want to become employed has changed hospitals’ attitudes toward recruitment,” says Max Reiboldt, CPA, president and CEO of healthcare consulting firm Coker Group.

These findings suggest a natural and progressive physician exodus from private practice into group practices and health systems, begging the question of whether physician recruitment is still imperative to hospitals these days.

The answer? Very much so.

“Recruitment efforts are still very much an issue for hospitals,” says Marc Halley, president and CEO of Westerville, Ohio-based Halley Consulting Group, a physician practice management and consulting firm. “Regardless of the model used, whether employment or an income guarantee, hospitals still have to recruit. In fact, for some specialties like primary care, recruiting is a lot tougher today.”

Phoenix-based Banner Health’s goal for 2011 was to hire 220 physicians. “We successfully met that goal,” says Anne Folger, senior director of physician recruitment for Banner. One of Banner’s strategies is to build Banner Medical Group, which is about three years old and has just over 800 employed physicians. “That number will continue to grow,” says Ms. Folger.

“The trend we’re seeing nationally is that both new graduates as well as seasoned practitioners are more interested in employment model.”

Certain demographic conditions and emerging models of care delivery are calling for hospitals to revisit their recruitment strategies to not only attract the number of providers they need, but specific qualifications as well. Here, experts weigh in on new trends in recruitment strategies.

Role of the hospital CEO in physician recruitment

“Is the hospital physician-friendly, or not so much?” That’s a crucial question physicians want answered when considering a hospital’s employment opportunities. The answer depends on whether physicians are appointed to leadership positions, whether incentives are aligned and other determinants. But the hospital and/or health system CEO plays a huge role in physicians’ perception of the organization. The physician culture will become evident during the recruitment period, meaning CEOs best be mindful of how they interact with medical staff. Word travels fast.

“Physicians will be exposed to other members of the medical staff, and medical staff will be very honest about what the institution and the CEO are like,” says Aimee Greeter, senior manager at Coker Group. “I can name certain CEOs who have pro-physician reputations. They’re communicative with medical staff, and even when making unpopular decisions, they are not hiding back in their office. They tend to be held in higher regard by the medical staff as a result.”

Aside from developing and maintaining a pro-physician hospital culture, CEOs can reinforce recruitment by acting as market managers. In this role, the CEO looks at the physician workforce holistically and continuously identifies opportunities for hospital-provider alignment. “Instead of CEOs being concerned about new pieces of diagnostic equipment, they’re very much concerned about having primary care physicians in the right neighborhoods to feed subspecialists affiliated with their hospitals,” says Mr. Halley. “Those market managers are, by nature, good physician partners. They understand the world does not revolve around the hospital — it revolves around an integrated system of care delivery.”

The curveball of accountable care organizations

With their emphasis on care coordination, team-based care delivery and evidence-based medicine, ACOs are demanding new qualities from physicians. According to a recent survey from the Mediscus Firm, 73 percent of healthcare executives involved in ACOs said the delivery model will change their physician recruitment goals or processes. Specifically, the majority of executives said they expect to increase recruitment efforts for non-physician providers, such as nurse practitioners and physicians assistants, to build up their provider ranks for ACOs.

ACOs are not only influencing the type of providers recruited by hospitals, but also the professional qualities and attitudes those providers hold. There is a delicate balance between attracting a large number of physicians to develop an integrated team, and recruiting physicians who have demonstrated potential throughout their residency. It’s not always easy to differentiate subpar from high-quality physicians, especially if the individual has just left residency. But hospitals still keep an eye out for time-tested predictors among candidates, such as productivity.

Hospitals want physicians who are quick to accommodate larger patient volumes. “When we start looking at potential folks coming out of training, we want to know how busy their residency was,” says Mr. Halley. “If they had a busy residency, they may have seen half a day’s work by their third year and be comfortable with that volume. If they saw eight to 10 patients in half of a day by their third year, and you say, ‘You need to get to 25, 28 patients a day,’ the doctors can say, ‘OK, I was almost there in my residency program.’”

Hospitals are also seeking nimble physicians who are open to team-based care, which is especially critical since advanced practitioners will play an expanded role in care delivery. In the Mediscus Firm survey, 78 percent of healthcare executives said a team-oriented outlook is necessary for physicians participating in an ACO. Ms. Folger says this trait is in high-demand at Banner, as well. “We are very much looking for folks that work well on teams. We look for someone who is very collaborative and has a high tolerance to changing environments, because we know we have to evolve,” says Ms. Folger.
Physicians who are motivated by quality incentives, familiar and adept with technology and use an evidence-based approach to medicine are also sought after by hospitals and ACOs, according to the survey. The catch is that few hospitals or healthcare organizations currently employ physicians with these skill sets in the present day: Only 2.4 percent of survey respondents said all of their physician staff meets criteria they outlined as desirable.

This suggests that while physicians may be seeking hospital employment in droves, hospitals — as employers — still need to identify the best hires who are compatible with the organization's plans for ACOs, patient-centered medical homes and other integrated delivery models.

**Urban versus rural markets**

To approach physician recruitment discussions as a one-size-fits-all subject is inexact, as strategy varies depending on a hospital's market and location. Rural areas are facing an especially challenging recruitment environment right now, since the nationwide physician shortage is exacerbated in markets or states that do not include major medical schools.

That setback is compounded by the fact that fewer physicians consider rural areas attractive for work. In the most recent Residents and Fellows Survey, 32 percent of respondents said they would not consider practicing in a rural area. On the flip side, 95 percent said suburban communities were their first or second choice for a practice location, while 84 percent named a metropolitan area in their top-two locations.

Here are a few specific trends and challenges facing rural hospitals in their recruitment efforts.

**Handling call.** Compared to their urban counterparts, rural hospitals rarely have as large a physician panel to handle call. This can hinder physicians’ interest since it poses a threat to work-life balance. “No physician wants to be on call every other day. That’s an infringement on their lifestyle,” says Ms. Greeter. To overcome this, some rural hospitals hire locum tenens physicians to provide coverage on those days the recruited specialist cannot or will not be on call.

Another less popular arrangement is when hospitals tell physicians outright that, upon employment, they are responsible for a specific number of days of call coverage, such as 10 days per month. Once the physician meets that responsibility, hospitals can send patients elsewhere for that specific specialty — something hospitals don’t prefer to do, especially for surgical or other high revenue-generating services, according to Ms. Greeter.

**Finding physicians connected to the area.** Sourcing candidates is a fine art for rural hospitals. As physicians who have lived within 100 miles of its location or have regional experience with the hospital are more likely to relocate to and stay in the area. The challenge is in identifying these men and women, which Mr. Halley recommends be done proactively. “Some communities will say we can’t recruit to our community and I’ll say, ‘Wait a minute. Where are all the medical students and residents from this region studying medicine today? Do you know where they are? What if we brought them home? Let’s go get them,’” says Mr. Halley.

**Perception of quality of life.** Compared to their urban counterparts, rural areas are generally perceived as less robust when it comes to schools, cultural diversity, entertainment and recreational opportunities. Isolated areas pose a significant barrier in physician recruitment efforts, but not all candidates are deterred from non-urban markets. Interestingly, some physicians’ inherent attraction to rural areas can outweigh financial considerations when choosing a practice setting.

In a survey, the Colorado Health Institute asked 711 rural physicians what factors they consider “very important” when choosing a practice setting. Respondents could choose more than one answer. Three of the top four responses related to lifestyle: 70 percent cited recreational and leisure activities as a very important factor, 55 percent said the setting must be a good place to raise children, 44 percent said opportunity for professional independence and 40 percent said the desire to retire in rural Colorado.

Professional factors, however, did not rank as high. Fourteen percent of physicians cited the chance to buy a practice or become a partner as a factor, while 13 percent cited earnings potential and 8 percent mentioned recruitment strategies as “very important.”

**Innovative recruitment strategies**

What are some recent developments in recruitment strategies from the past five or 10 years? Many hospitals have refined and returned their strategies to become more business-savvy, aggressive and appealing to physicians just completing their training. Here are four tactics our experts have seen more of in recent years.

**Promotional tools.** More hospitals and health systems are developing formal promotional documents to inform physicians about their hospital's culture, community and employment benefits. Hospitals are creating and distributing a document called a “practice opportunity prospectus,” which outlines information about the practice opportunity, the physician's potential compensation, the hospital's medical staff and surrounding competition, the greater community, and other key points of consideration.

Such promotional tools are a change from what was used to be a more relaxed approach to recruitment, according to Mr. Halley. “It was more like, ‘Give me your curriculum vitae and 1’ll tell you more about the practice. If we like one another, we’ll chat and visit, and then maybe we’ll give you an offer.’ Now hospital recruiters are trying to truly understand what the physician is after, and do a better job matching those desires to what [the practice has] to offer,” says Mr. Halley.

Current recruitment efforts have also become a bit more slick and savvy, largely due to tools like social media and other technological perks. “We use everything,” says Banner’s Ms. Folger. “We use video-conferencing for interviews so we can have live discussions with [candidates]. We tap into residency programs around the nation. We use technology that allows us to identify physicians who may have family in a particular region and may want to return to it. It’s a full-court press with all the technology available to us.”

**Recruiting in high schools.** Connection is the keyword for rural hospitals’ recruitment efforts. Does the physician have family in the area? Did the physician grow up nearby? Rather than retroactively trying to recruit physicians who moved away to complete their training, some rural hospitals and health systems begin recruitment efforts proactively and early — even when students are still in high school.

“One hospital will go into the high school and say, ‘Look, if you’re interested, we’ll support you if you come back and agree to work in the community,’” says Mr. Reiboldt. Hospitals will offer to fund a portion of students’ medical school expenses if he/she agrees to return and practice in the community for an agreed-upon amount of time. “This will try to help motivate [students] to go all the way through medical school and then come back.”

**Incubation models.** Another recruitment strategy, known as the incubation model, has been implemented for a while in the healthcare community, but Ms. Greeter said it is picking up speed. Under this model, a physician who moved away to complete their training, some rural hospitals and health systems begin recruitment efforts proactively and early — even when students are still in high school.

“As soon as a hospital finds a physician who is interested, they’ll support you if you come back and agree to work in the community. This will try to help motivate the community.”

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The model has its perks for all parties, according to Ms. Greeter. “For the practice physicians, it’s like having another partner, but they don’t have the financial risk,” she says. “For many physicians coming out of medical school who want to be employed, this is an attractive model. It has the security of employment and the autonomy that comes with private practice.”

Opportunities for philanthropy. A 24-bed hospital in the rural Midwest made headlines this year for its unique recruitment strategy. Located in a town with no more than 900 people, Ashland (Kan.) Health Clinic offers potential candidates eight weeks off for missionary work overseas. The tactic is rooted in the idea that a physician who is willing to endure harsh conditions abroad, such as practicing in the aftermath of a natural disaster, might be willing to relocate to a rural location to eliminate disparities in care.

10 Steps for Hospitals to Follow to Recruit New Physicians

By Darrell Pile, Executive Advisor, Outpatient Healthcare Strategies

I’ve been a hospital administrator for nearly 30 years and have helped lead a variety of hospitals in urban, suburban and rural settings. Whether or not our plan was to gain market share or to fill gaps due to retirements, physician recruitment has been part of every strategic plan.

The single most important ingredient for a successful strategy is for the entire administrative team to become involved and to analyze the process from the candidate’s perspective. Everyone can play a role, whether it’s the front receptionist who greets the candidate by name, the staff on the floors during a tour, to the entire executive team that has helped to identify the need and opportunity. Everyone should realize that a long-term relationship with a new physician can generate millions for the bottom line and help secure futures.

By following these 10 steps, a hospital team will position itself to wisely compete against other hospitals in order to be a candidate’s top choice.

1. Know your community need and convince candidates that there is a predictable long-term demand. The decision to join a hospital for physicians is among the toughest they will make. Successful use of their training and academic accomplishments will either be facilitated or compromised by this decision.

Be able to describe why you are so certain that there is a need for the physician. Show third-party data that demonstrates a shortage for the specialty within key parts of your service area. Describe current wait times and population growth projections. Likewise, describe what your board or your medical staff has said regarding the need to fill the position. If possible, introduce the candidate to them.

Before meeting, know the financial parameters of your offer. Speak confidently in the first visit about an income guarantee, startup assistance or malpractice coverage, and other incentives. Describe the terms of your standard recruitment agreement. Show that you, too, are willing to take a financial risk because you are so certain about the opportunity.

Describe options for an office. Show the different locations, the pros and cons and your top recommendation. Of strategic importance, select potential office locations wisely. Perhaps the candidate should join an existing group with an agreement. Or, possibly your hospital is wise to establish a new office within the growing market. I suggest you structure your recruitment agreement in accordance with advice provided by your legal counsel. The agreement to join a group and an agreement to open a solo office must each be written in a fashion that satisfies applicable law.

2. Conduct a thorough initial telephone interview. When you reach the physician by telephone for an initial interview, the information you gather must go beyond medical training and experience. Be sure to learn what types of patients he or she wishes to treat within the specialty. For instance, if you are looking for a family medicine physician to serve as a gatekeeper and referral source for your specialists, be sure to have that discussion in advance since the candidate may instead plan to have a wide scope of services offered without the need for many referrals. These details are important to find out ahead of time.

You also want to learn about the physician’s personality, special interests and leisure activities. Find out if the physician is married. Learn about the spouse’s career and ambitions. Ask if the candidate has children, how old they are and their interests. What are the physician’s hobbies? What type of home is the physician looking for? Where does the extended family live? What would make a near perfect situation for him or her?

As you ask these questions, you will learn more about the personality of the physician and raise your own comfort level as you look for the “right fit.” You are working to form a long-term relationship with someone who is getting ready to make a life-changing decision — a decision you hope will favor your facility.

3. Conduct a follow-up interview. You will want to conduct a second telephone interview before scheduling a visit. In advance of the call, consider a web search of the candidate or the name of his or her current employer or clinic. During this call, provide answers to questions asked in the first call, ask any additional questions and revisit the same type of questions you asked during the first call but approaching them in a different way. You will want to confirm that you receive the same answers and reaffirm your initial impressions.

4. Prepare for the site visit. An effective site visit entails much more than just setting up
a date and time to meet the physician. Try to schedule the meeting on a day when you have time to genuinely talk without much mental distraction. Always remember that the candidate is absorbing as much verbal and nonverbal information possible. Distractions will likely be regarded in a negative way.

In fact, your entire team should be ready to show genuine interest in the candidate. If the CEO is not the lead person for the site visit, ensure that when the CEO meets the candidate, the time is genuine, not rushed and not “squeezed” into the schedule. Avoid causing the candidate to feel like he or she is an interruption for the CEO.

Likewise, take steps to ensure a pleasant visit. You should set up the physician’s hotel near your hospital and make sure transportation is in place — from an airport to the hotel, from the hotel to your hospital and then back. You’re going to want to show the physician that your facility is organized and you care about and want to accommodate him or her. Likewise, pay for travel-related expenses in advance rather than requiring the candidate to submit air, hotel or rental car receipts for reimbursement.

Think through the tiniest of details. For example, the front desk personnel should know that there is a new physician candidate coming for an interview and when he or she is expected to arrive. By knowing in advance, they can provide the warmest greeting the physician will likely receive from any other facility the candidate visits.

5. Conduct the tour. The tour should be planned well in advance, and the individual leading the tour, whether it’s the medical director or perhaps the chief nursing officer, should know exactly where to take the physician. During the tour, you will want the physician to see the areas where his or her patients will be treated. You will want to bring the physician to your ICU and ER. Also consider bringing the physician by your lab to talk to the pathologist about turnaround times and stop by the reading room in radiology so the radiologist can tell the candidate about the procedures they do and read times. Tell the physicians in these departments that a candidate is coming ahead of time so they are prepared and can have the candidate’s profile in their mind.

You’re also going to want to make sure employees in these various departments know there’s a potential new physician coming for a tour, what his or her name is and when the physician is expected to arrive. Selected staff members should be encouraged to greet the candidate, discuss their work and speak about the team and the community.

I encourage hospitals to plan as much of the tour as they can before the physician arrives, even seemingly insignificant details, such as lunch. Sometimes the most effective lunch can be held impromptu in the physicians’ dining room. On the other hand, it may be wise for lunch to happen in the conference room with selected physicians.

6. Arrange for meetings with various members of the C-suite. During the visit, make sure your candidate has an opportunity to meet and talk with members of your C-suite. Discuss the candidate in advance and provide every member with the candidate’s resume. Each leader can benefit by learning about the discussions held by telephone interview, and each needs to understand the need to fill the position. This will enable your key representatives to build from what has been said and to help affirm your impressions. Each member can also help to assess the personality of the candidate. For instance, while the CFO may be helpful in answering income guarantee questions, he or she may also be helpful in discussing neighborhoods that may interest the physician or to discuss other topics in common.

If these meetings last just 5 to 10 minutes, by having C-suite members stop by, they will show the physician that the hospital’s leadership (often “invisible” to physicians) appreciates the candidate and the challenge of the decision he or she is facing. These discussions will likely leave a powerful and lasting impression on the candidate, and may help the hospital stand out from other organizations.

7. Describe growth opportunities for the physician’s practice and your hospital. Most candidates are forward thinking. Be in position to describe his or her likely success in one year, three years and five years. Describe what your hospital is doing to build market share and to promote utilization of its services over those of competitors. Discuss potential physician referral sources for the new physician to meet. Describe again the unmet demand and why you are certain he or she will build a busy practice. Share ideas on how other new physicians market their practice. By the way, something as simple as Saturday morning hours is not a bad idea.

8. Personalize the visit. While it’s certainly important to give the candidate a good impression of your hospital, there are many other factors likely to determine where the physician ultimately chooses to work. In the past (and especially if a second onsite visit occurs), I have spent time arranging for a realtor to show candidates homes throughout the community. Although a new physician may not be ready to buy a house, it is a great way to acquaint him or her to the community. The realtor would come to the hospital to pick up the candidate during the visit and bring the candidate back to the hospital.

I’ve taken time to help find jobs for spouses. I’ve arranged for tours of private schools, and made sure the principal of the schools was available for the physician and spouse. In some cases, the physician may be interested in places of worship, and you will want to arrange visits at these institutions as well.

You need to find out all of these details ahead of time — likely during the telephone call interviews — so you can personalize the visit. Remember: You’re trying to form a relationship with someone who has a lot to lose by making a bad decision and relocating to an area that does not meet his or her needs. And by the way, the members of your community who meet with the candidate, including the realtor, can be a great source of feedback for you to build upon.

9. Identify employees who may help answer specific community questions. From swim teams to soccer leagues, church groups, flying lessons, horse stables, Boy Scouts or even adult tennis leagues, your own employees can be your best sales representatives. Do whatever it takes to help a candidate envision the transition to your community. Remember: You may be recruiting an entire family unit. They are also helping the candidate select the best location.

10. Keep building the relationship after the visit. Within two days after the visit, key members of your team should send a thank you note to the candidate. It is also a good time to send additional material about key lifestyle interests that you learned about during the interview. Consider sending a booklet describing your community, or nearby horse stables or communities with tennis courts, etc. Your chamber of commerce may be a great source for that information as well as new community home centers (since they also tend to promote all attributes of your area). In short, take one more step to give your recruitment approach an added touch.

By the way, be sure to cast many lines into the water. I have found the most success in recruiting new physicians by using three or four contingency search firms simultaneously (but make sure to keep track of situations where the same candidate may be submitted to you by two or three different companies). Stay in touch with the recruiters and be the squeaky wheel. They also want to work with hospitals that are serious about placing candidates.

Finally, the odds of recruiting a new grad this coming June intensifies in December and January. Planning ahead is wise since most physicians will choose their organization by February.

Darrell Pile is an executive advisor for Outpatient Healthcare Strategies (www.outpatientbs.com), a provider of healthcare consultancy services for hospitals, ambulatory surgery centers and physician group practices based in Houston.
Leadership is Central to Healthcare System Reform

By Judith D. Bentkover, PhD, Executive Master of Healthcare Leadership, Brown University

The centrality of leadership

The recent report from the Institute of Medicine, “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,” is a powerful wake-up call to the nation. As the IOM report attests, “American healthcare is falling short on basic dimensions of quality, outcomes, costs and equity.” The human and financial costs of our health system’s shortcomings — an estimated 75,000 fewer deaths if the quality of care in every state matched the highest performing state and $750 billion in waste and inefficiency — underscore the urgent need for fundamental transformation of the healthcare delivery system.

Incremental changes are simply insufficient to attain our goal of delivering higher quality care at a reasonable cost to all Americans. It is clear that we need all healthcare stakeholders to commit to creating an integrated, patient-centered system that embraces continuous improvement, promotes greater teamwork and transparency, adopts new technologies for collecting and utilizing clinical data to improve performance at the point of care, engages patients and families in managing care, emphasizes value and care outcomes and is digitally connected so that patient-provider-caregiver teams have complete, shared patient information and access to relevant medical research and care protocols.

Undertaking the scale and complexity of necessary changes demands leaders who are able to recognize flaws, articulate a vision for the future, lay out a path for getting there, inspire change and hold the overall organization responsible. Technology can only facilitate but does not drive large-scale change. Leaders are the essential agents for converting these challenges into opportunities.

I would posit five characteristics of effective leadership that are critical to moving the entire healthcare system toward greater effectiveness, efficiency and equity:

1. Forging a new culture. The most critical task of any leader is setting the tone at the top and working to infuse a culture of excellence throughout the organization. Organizations can only progress if their members share a set of values and are single-mindedly committed to accomplishing clearly defined goals.

The six-hospital Henry Ford Health System in Detroit has succeeded in radically recasting its culture of patient safety. Championed by the CEO and board, the organization has carried out a vigorous campaign for eliminating all patient harm, including the development of a single patient harm index to monitor progress and hold the organization accountable. The patient safety message is fully interwoven into their communications, training and even employee recognition, with the result that Henry Ford has succeeded in rapidly reducing the number of harm events.

2. Using empirical data to foster continuous learning and improvement. The rapidly accelerating amount of information available to clinicians and administrators for delivering and managing care is, according to the IOM report, “too rarely applied to improve the care experience.” Having access to large amounts of data is not sufficient; the organization must be committed to applying that data and to creating processes that leverage data to drive continuous learning, innovation and improvement.

Geisinger Health System of Danville, Pa., has made great strides in implementing what it has called its “innovation architecture,” which involves engaging employees in the use of data to redesign care models to achieve higher quality, more efficient care. Further, the organization encourages sharing of information across disciplines and adapting approaches that have worked elsewhere in the system.

Marshfield (Wis.) Clinic has not only invested in a robust electronic health records system, it uses the data it gathers to evaluate clinical practices against evidence-based medical guidelines and to identify and address gaps in care on a real-time basis. It constantly evaluates which clinical groups are in fact utilizing data to improve performance.

3. Collaborative over top-down approaches. Healthcare is so complex that no leader can accomplish much without the support of key stakeholders, such as clinicians. As physician and writer Atul Gawande, MD, suggests in his recent “Big Med” article published in The New Yorker, engaging key stakeholders early on can help leaders overcome the resistance that often accompanies efforts to “persuade clinicians to follow the standardized plan.”

When Dr. Gawande’s own institution, Brigham and Women’s Hospital in Boston, embarked on a campaign to standardize joint-replacement surgery, the hospital brought together every specialty involved, including surgeons, anesthesiologists, nurses and physical therapists, to examine all medical evidence and formulate a single standard for knee replacements. Even after the protocol was established, the hospital allowed surgeons to deviate from the plan if they had a compelling reason. And still it took the better part of a decade to get there.

4. Engaging the patient. The need for more collaborative approaches also extends to patients and families. Research increasingly links patient education and engagement to better health outcomes, lower costs and an enhanced care experience. With the rise in chronic conditions, the incidence of which is tied closely to patient behavior, engaging patients will be paramount to any long-term effort to enhance health and reduce costs. Kaiser Permanente HealthConnect, which facilitates greater patient access to their healthcare records, information and physicians, has been associated with improved quality of care in studies.

5. Accountability. Finally, leaders need to establish clear lines of responsibility and institute performance-based compensation systems aligned with cost and quality goals. This also requires leaders who are willing to be transparent about measuring the organization’s performance against a range of metrics. Establishing these kinds of performance and compensation systems can entail higher degrees of risk for the organization (for example, when Geisinger moved to a performance-based compensation system, it initially experienced higher levels of physician turnover). But leaders can’t shy away from taking these kinds of risks in order to leverage internal and external pressures for radical change.

Conclusion

In distinguishing leadership from management, the former is doing the right things and the latter is doing things right. Ultimately, the transformations of today will become operationalized and embedded into the systems, processes and standards of tomorrow (for example, evidence-based care protocols being incorporated into decision-making software). In the meantime, it is imperative that the healthcare system recruit and train leaders who can advance the kind of systemic reforms necessary to surmount the current healthcare crisis.

Judith D. Bentkover, PhD, is an adjunct professor of Health Services, Policy and Practice at Brown Alpert Medical School and the academic development director in the Executive Master of Healthcare Leadership program at Brown University in Providence, R.I. She is also president and CEO of Innovative Health Solutions, a consulting firm providing research and strategic analysis to healthcare manufacturers, providers, and payors, and professor of the practice in the Economics Department at Tufts University in Medford, Mass.
5 Areas Where Hospitals Can Spend Smarter

By Bob Herman

With reimbursements from Medicare, Medicaid and commercial payors shrinking, hospitals and health systems are exercising greater prudence on where they are spending their money.

For CFOs and financial departments, this means every purchase and every other fiscal strategy has to pass a stricter test to ensure the hospital is not dumping funds into fruitless projects.

Here are five areas where hospitals can better spend their money and tips on what CFOs and others can do to avoid wasting precious capital and money.

1. Consultants. Healthcare reform has somewhat pushed hospitals and health systems into a corner. The organizations must adapt to the new accountable care-based environment, but they still have to manage their finances along the way. This has opened the door for many consulting firms to help hospitals who may have trouble handling everything.

Dan Moncher is CFO of Firelands Regional Medical Center, a 400-bed academic medical center in Sandusky, Ohio. He says while some consulting firms have the ability to work positively with hospitals in times of financial duress, CFOs must exhibit caution and thoughtful decision making before they make a financial commitment.

“This is a global comment, but every time a new rule or regulation comes out, a lot of money is wasted on consultants,” Mr. Moncher says. “Not a day goes by where I don’t get a handful of phone calls and emails where someone says, ‘I can save you $1 million, and I’m not going to charge you unless it works.’ Be wary, with all due respect, on projects that involve new revenue and saving dollars.”

2. Vendor contracts. For Paul Summers, CFO of UHS Delaware Valley Hospital, a 25-bed critical access hospital in Walton, N.Y., hospitals can always improve on their vendor contracts.

UHS Delaware Valley Hospital is part of UHS, a health system with four acute-care hospitals scattered throughout south central New York. Mr. Summers says because his hospital is part of a system, it is able to enjoy bulk purchasing benefits. However, hospitals should not merely be content with their contracts, even if they are in a group purchasing organization. They should routinely stay in contact with vendors to make sure all contract terms are upheld, such as pricing discounts.

“Most of these contracts have built-in escalation clauses based on the consumer price index, so you have to make sure you’re checking that,” Mr. Summers says. “Make sure vendors are being compliant on their end.”

Mr. Summers also recommends hospital CFOs and supply chain managers closely collaborate together during negotiations of new contracts. In today’s tough economy, suppliers, vendors and especially those looking to sell expensive capital equipment are eager for any customer, and that puts the ball in the hospital’s court.

“When you’re conducting upfront negotiations on the price of a piece of capital, it’s an opportune time to get concessions from vendors because they are interested in selling that piece of equipment,” Mr. Summers says.

3. Real estate. Marisa Manley, president of Healthcare Real Estate Advisors, has worked with several hospitals and surgery centers over the years on their real estate portfolios — an area she says hospitals can waste significant amounts of money.

“It’s important to know 40 percent of hospital assets are tied up in real estate,” Ms. Manley says. “That’s a significant amount of capital. If hospitals can be more cost-effective in their use of real estate, you can have a significant effect on the bottom line.”

She says instead of looking at the problem as one of “wasting money,” hospitals should look at it as utilizing their current real estate portfolio more effectively. For instance, hospitals should consider long-term leases of medical office buildings instead of constructing new ones. Two examples of innovative real estate projects include Holy Spirit Hospital in Camp Hill, Pa., and Genesis HealthCare System in Zanesville, Ohio. Earlier this year, Holy Spirit turned one of its properties, a former strip mall, into a data center, and in 2010, Genesis sold the leases of its non-hospital properties to a real estate investment trust to fund its electronic health record system.

“You can save money by strategically managing your entire portfolio,” Ms. Manley says. “Look at best practices because you’re not reinventing the wheel.”

4. Expansion of service lines. For hospitals, expanding service lines may seem like an easy, simple way to boost revenue and profitability, but many times, if not done right, those efforts could be a boondoggle. For example, if a hospital is in an area rich with cardiology services, will it make sense to branch out with a new freestanding heart center, or will it dilute the market?

“Certainly service lines just don’t have the volume to back [them] up,” Mr. Summers says. “So we do a pro forma, profit/loss analysis on any particular service we may want to add. If that service won’t yield a return of 10 percent, we won’t do it.”

However, profitability also needs to be balanced out with the hospital’s mission of providing necessary services to the community, and this is especially important for non-profit hospitals and systems.

“It frustrates you when you know resources are being wasted when [capital] could go to the underinsured or uninsured, or maybe a free clinic could’ve been built,” Mr. Moncher says. “Communities don’t need 17 imaging centers. Capital resources can be used in a better way to serve the community.”

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“There is a lot of waste of capital dollars with people duplicating services,” Mr. Moncher of Firelands Regional says. “Where we are located, one freestanding cancer center popped up, and now there is way too much capacity with linear accelerators in our region. It wasn’t really necessary.”

Instead, Ms. Manley of HREA suggests hospitals take a calculated, strategic approach when they open new lines of service off campus. Look around to see if other ambulatory surgery centers or hospitals already provide the service, and then if the service could be provided, consider reusing or repurposing existing facilities to provide that service.

Mr. Summers agrees that all hospitals, especially smaller community hospitals, cannot be all things to all people. Evaluation, along with valuation, must be conducted.

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5. Electronic health records. EHRs are a major investment for hospitals, usually costing millions of dollars. For large health systems with multiple facilities and physician practices, EHR investments could top eight figures.

Mr. Summers of UHS Delaware Valley Hospital says everyone in the healthcare sector has “jumped on the EHR bandwagon” to meet the government’s meaningful use standards, but EHRs are more than just federal incentive dollars. Hospitals must invest in the right EHR because that system will impact the day-to-day activities of physicians, staff and, most importantly, patients.

Currently, UHS Delaware Valley Hospital is on its third EHR vendor in the past eight years, and Mr. Summers says he finally believes the hospital has found the right system. For other organizations, he recommends executives do their homework and go with a health IT vendor that has a credible background and is in the health IT game for the long run.

“Even though it might be an inexpensive EHR, you don’t just want to jump for it due to the price,” Mr. Summers says. “You want an EHR vendor that’s in it for the long haul and can conduct research and development to expand that product.”

For CFOs who are unsure of certain projects and whether they will create a batch of red ink for their hospital, there is always a foundational resource — peer networks.

“Utilize your peer networks,” Mr. Moncher says. “HFMA, ACHE, the American Hospital Association, your state hospital association — it’s the global assumption that they all exist for the greater good in general.”

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**Which Insurer is Most Willing to Offer Performance-Based Contracts?**

By Molly Gamble

Out of seven major payors, providers ranked UnitedHealthcare last when it came to overall satisfaction but second for willingness to engage in innovative payment models, according to a Medical Group Management Association survey.

In its fifth annual survey, MGMA polled nearly 800 physician practice professionals on payor communications, provider credentialing, contracting, payment policies, system transparency and the payors’ willingness to engage in innovative payment models.

Here are some key rankings from MGMA’s 2012 report.

**What is your overall current satisfaction with the payor?**

A score of 1 reflects “completely dissatisfied” while a score of 5 reflects “completely satisfied.”

- Medicare Part B — 3.53
- Cigna — 3.20
- Aetna — 3.16
- Coventry — 3.00
- Anthem — 2.99
- Humana — 2.83
- United Healthcare — 2.77

**How willing is the payor to engage in innovative payment models or offer new/innovative contracts based on concepts such as accountable care, shared savings, medical homes or payment bundling?**

A score of 1 reflects “completely unwilling” while a score of 5 reflects “completely willing.” A score of 2 reflects “moderately unwilling.”

- Medicare Part B — 1.95
- United Healthcare — 1.82
- Aetna — 1.80
- Cigna — 1.76
- Humana — 1.74
- Anthem — 1.75
- Coventry — 1.66

**How transparent to you are the cost and quality measures used by the payor for its physician rating and/or pay-for-performance programs?**

A score of 1 reflects “no transparency” while a score of 5 reflects “complete transparency.” A score of 2 reflects “slight transparency.”

- Medicare Part B — 2.73
- Anthem — 2.14
- United Healthcare — 2.07
- Humana — 2.07
- Cigna — 2.06
- Aetna — 2.04
- Coventry — 2.02

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9 Strategies for Robust Healthcare Due Diligence

By Kathleen Roney

Due diligence is a necessary step in any transaction. Whether it is a clinical affiliation or a full sale, due diligence is conducted so both parties fully understand the other. Often, the best due diligence process is one that is robust, involving substantial interaction and discussion between the parties, and most likely resulting in a detailed understanding of the operational performance of each party.

According to Bill Baker, partner and head of transaction services for healthcare at KPMG, due diligence is similar to dating before marriage. During due diligence, each party prefers to put its best foot forward, refraining from revealing any negatives, just as in dating. It is usually after the marriage or the deal — when it is impossible or extremely difficult to undo a transaction — that negatives come to light.

“If a hospital relies solely on the other party to fully disclose without a robust due diligence process, it will find only positives, which could be misleading,” says Mr. Baker.

Due diligence is a very complicated process because a lot of factors and issues must be covered, even more so with organizations that are as complex and regulated as hospitals and health systems. Here are eight strategies that could prove useful to executives and board members hoping to ensure a robust due diligence process for their organization.

1. Address due diligence as early as possible, ideally before governance negotiations. Mr. Baker recommends addressing due diligence as one of the first steps in a transaction process — before the governance of a deal is negotiated — because fully understanding a potential partner is beneficial in realizing the true benefits of a transaction. However, Mr. Baker does acknowledge that due diligence is not always easy to conclude prior to governance discussions.

“It is not unusual to agree on governance before initiating due diligence because not every potential partner wants to lay all their cards on the table. [For this reason], many parties allow due diligence caveats — transaction terms are not locked in until due diligence concludes,” says Mr. Baker.

According to Dale Van Demark, JD, partner at EpsteinBeckerGreen, due diligence can be conducted even as a definitive agreement is signed. “In a perfect world, due diligence is conducted before and after a letter of intent. In those instances, the due diligence is utilized to modify terms of the letter of intent,” says Mr. Van Demark.

2. Hold a call or meeting with senior leadership. According to Scott Becker, JD, CPA, partner at McGuireWoods, a call with the potential partner’s senior leadership should be done as soon as possible. During the call, questions should be asked to give each party a feel for what the key issues are.

“In a pretty short period of time, you are going to have to do a ton of detailed follow-up to close the loop, but you can get a good sense of the key and challenging issues [from a call with senior leadership],” says Mr. Becker.

“From there, you figure out further due diligence. You want to make sure the individuals reviewing the documents and information are focused on the key areas, the ones likely to be trouble. This way the process is not an endless waste of time, but a focused process.”

3. Develop a game plan or strategy. Since due diligence is complicated by nature and many factors are involved, healthcare executives need to think through a strategy for due diligence before the process begins.

“The best sort of due diligence process begins with a game plan [or strategy], and it proceeds along that game plan, only changing as dynamics of the due diligence changes or as [new issues] are discovered,” says Mr. Van Demark.

While sticking with the strategy is crucial, Mr. Van Demark recommends flexibility. “You have to be able to modify plans in order to react to changes,” he says.

4. Use a checklist. According to Michael Daray, lead attorney in the healthcare practice at Law Weathers in Grand Rapids, Mich., a checklist of issues to cover during due diligence should be created as soon as possible.

“It is more of an organizational issue. It helps clarify the important items that the respective parties need to focus on. If you don’t have some sort of checklist, it’s easy to get bogged down on certain issues while neglecting others. From an organizational standpoint, the checklist puts everyone on the same page as for what needs to be done,” says Mr. Daray.

Ten key topics should be included on the due diligence checklist:

- Legal matters
- Financial matters
- Indebtedness
- Assets
- Regulatory matters
- Environmental matters
- Contracts
- Employee matters
- Insurance
- Litigation

5. Prepare for anything and know the deal breakers. It is likely that a variety of issues will surface during a due diligence procedure, so hospital executives and board members need to be ready to deal with due diligence that veers off course.

“You have to be ready to contend with issues that come up out of the due diligence process and recognize that as a part of what due diligence is for. Due diligence gives each party the opportunity to assess and, in many instances, modify aspects of an agreement to deal with issues,” says Mr. Van Demark.

For this reason, a hospital also needs to understand and determine its deal-breakers in advance, so that when problems arise, no member of the board or executive team is caught off-guard or unprepared to make decisions. “Hospitals conduct their business in a highly regulated industry where there is a lot of risk. Organizations need to understand their risk tolerance in respect to diligence, because once an agreement is final, you can’t get rid of that risk,” says Mr. Van Demark.

6. Encourage full investment from all parties. Mr. Van Demark believes that the most successful due diligence occurs between two or more parties that really embrace and understand the process, especially the time and resource commitment that is necessary.
Transactions & Valuation Issues

“Due diligence needs to be conducted in a deliberate manner so that vast amounts of information and numerous issues can be identified at both a technical and managerial level, at the appropriate time, so appropriate decisions can be made,” says Mr. Van Demark.

According to Craig Garner, JD, former CEO of Coast Plaza Hospital in Norwalk, Calif., cooperation from both sides helped to streamline due diligence when he was negotiating the sale of Coast Plaza to Avanti Hospitals in El Segundo, Calif. Mr. Garner's willingness to respond to all of the requests for information about Coast Plaza — during multiple phases of diligence — helped the deal conclude successfully.

“I wanted to make sure that we made all disclosures. I wanted to do this only once, and do it right,” says Mr. Garner.

Without full effort and participation from both parties, an issue may fall through the cracks, or certain information will not come to light at the appropriate time.

7. Don’t lose sight of the purpose of due diligence. Due diligence itself can take a very long time and it is common for organizations to forget why they are doing due diligence, says Mr. Van Demark. Most organizations never lost sight of the business perspective of the process — how it provides a financial perspective to operations — but they forget that due diligence should inform modifications to the transaction agreement.

“When organizations forget to review or modify the rights and obligations of the parties in respect to each other, depending on what is revealed in due diligence, than the process was not fully useful. Hospital executives need to remember not to get caught up in closing the deal,” says Mr. Van Demark.

8. Enlist advisors and legal counsel for assistance through the process. As mentioned before, due diligence covers many complex areas within a hospital’s operations — financial, legal, compliance and so on. Due to the complexity of healthcare organizations as well as the complexity of topics, Mr. Baker advises that hospitals involve financial and legal advisors who have experience performing due diligence in a healthcare setting.

“Individuals with experience know what to look for, what areas to prioritize, the questions to ask and what risks to address,” says Mr. Baker.

While advisors and legal counsel are not necessary in order to conduct due diligence, the experience they often bring is a good indicator of success for the deal. According to Brian Kerby, CPA, director of transaction services group for Crowe Horwath, some hospitals or health systems have experience in transactions so they may be more familiar with due diligence — they may have more experienced executives and/or in-house legal counsel.

“The hospital board or executives need to ask themselves: Are we experienced in due diligence? Have we done this historically? The answers to these questions are good indicators of whether or not advisors are necessary and to what extent,” says Mr. Kerby.

9. Prepare to navigate politics. Due diligence can stir up some sensitive or controversial issues, adding the dynamic of politics to the already complicated process. According to Mr. Baker, it is possible for politics in discussion to cloud what should be appropriate, standard due diligence procedures. Typically the politics arise around the closing of the transaction when the parties begin to visualize the changes and operations post-closing.

“Typically [politics become a factor] during the lengthy discussions and negotiation around what a merged board or executive team looks like immediately post close as well as how it may evolve over some predetermined period of time,” says Mr. Baker.

Unfortunately, politics can distract and/or delay the due diligence. This is why professionals suggest covering governance and post-closing structures early on. “[It is] an instance where experienced advisors play a key role. They may be better at probing for information amid sensitivity and tension,” says Mr. Baker.

When participating in a healthcare transaction — a merger, acquisition, full sale or affiliation — there is no way to avoid due diligence. The above strategies will help hospital executives and board members conduct robust due diligence to satisfy their needs, state and regulatory officials and any other parties with a stake or interest in the deal or its outcomes. Overall, robust due diligence is pivotal because the more one partner knows about another and vice versa, the better — in a transaction or a marriage.

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Operating rooms are one of the most costly areas of hospital operations, and as hospitals face a range of mounting financial pressures, most are reexamining OR operations for any avoidable costs.

Despite ORs being such a pillar for hospitals’ profitability, there is little published, formal data on true OR costs. For instance, there are far too many variables to accurately determine how much one minute of OR time costs.

As a result, hospital administrators often deploy a ballpark to answer that question, ranging from $15 to $20 per minute for a basic surgical procedure, according to research from Stanford University School of Medicine. That range illustrates the significant price hospitals pay for any inefficiencies or unexpected events in the OR, such as last-minute cancellations or delays due to missing imaging equipment. Furthermore, the cost per minute can easily surpass $20 depending on the complexity of the procedure, if fixed overhead costs and/or physician fees are included, how the OR staff is paid and other variables.

Although OR costs and potential profits are prone to an array of variables, one thing is certain: Time is an OR’s most valuable resource. Even a slight delay in a case’s start time, a lengthy turnaround, or a few minutes spent looking for a piece of missing equipment, can severely hinder an OR’s efficiency and ability to maintain a positive contribution margin.

Non-labor costs are an attractive area for hospital management to reduce, as they are of a “low emotional level,” according to Jeff Peters, president and CEO of Surgical Directions. These cost reductions do not involve layoffs or reclassification of staff. Plus, non-labor costs also make up anywhere from 40 to 60 percent of total OR costs, according to Mr. Peters.

Here are six cornerstones of OR operations, along with some best practices to make them more efficient.

1. Building support among physicians to reduce supply costs. The first step in OR efficiency is for hospital management and OR managers to analyze costs by procedure and by surgeon. Sharing this cost information with surgeons typically builds their acceptance that they may need to alter their practice or resources. “The second thing you want to do is look at high cost items and benchmark them to national standards. Those are things like implants, supplies and devices,” says Mr. Peters. “I recently worked with an 11-room OR in the south. They found that their implant costs were 50 percent higher than the national average.”

If a device, implant or other product exceeds national benchmarks, the hospital CMO, chairman of surgery, OR manager and other clinical leaders should meet with the surgeon to establish a ceiling price. “You present that information to the surgeons and say, ‘I want to get these costs down. I don’t want to impact your practice, but I need your support as I talk to your reps about the fact that we’re going to establish a ceiling price for implants,’” says Mr. Peters. He says most organizations have reduced their implant costs by 20 percent to 25 percent by establishing ceilings.

Another tactic is simple: label OR supplies with price information. “You want to build awareness among staff about the costs of supplies,” says Mr. Peters. Often, OR staff will open supplies that go unused. By labeling the price on those materials, staff will become more cost-conscious and may change their habits toward supplies.

2. Blocking time. Generally, the most efficient way to block OR time is by the day as opposed to stints of hourly blocks, with each less than eight hours. For instance, a 12-hour block is ideal for specialties that involve longer cases, such as spinal surgery. Even an eight-hour block can allow surgeons to perform up to three procedures.

An extended block allows one specialty or surgeon to utilize the OR all day, as opposed to a four-hour block time that can handle one procedure. Hourly blocks four hours or under may also result in cases running over their allocated time or mid-day gaps in utilization.

As more profitable surgical cases move to freestanding surgery centers or surgical hospitals, ORs are also facing growing pressure to factor the profitability of a surgeon’s cases into block time grants. Despite hospitals’ focus on economic incentives, granting block time based on the profitability of cases is subject to organizational politics. If surgeons learn that cases or block times are denied based on financial metrics, it won’t take long for them to take their cases elsewhere. Rather than denying surgeons block time based on case profitability, it is recommended that hospitals deploy a more positive strategy and work to attract local surgeons who may bring a potentially lucrative caseload to the hospital.

3. Adjusting OR block time and releases. Traditionally, block times have been adjusted based on surgeons’ utilization rates, but recent research has suggested this may not be the most accurate criteria to make that decision. The hospital can still lose money through a surgeon with a high utilization rates if the reimbursement for his or her case does not cover the costs.

Instead, OR managers may be better suited to adjust block times based on the balance between under- and overutilization of the OR. For instance, an underutilized OR equals a financial loss for the hospital, as there is no revenue coming in. But an overutilized OR can result in cases going over schedule, decreased satisfaction among clinicians, and the hospital having to provide overtime compensation. Thus, OR managers should try to match case workloads to staff levels when adjusting block times.

Block releases are one way for OR managers to instill more flexibility in the OR schedule. A release refers to a block time that is not scheduled for a procedure. Building release times into block schedules far in advance allows schedulers to add cases to blocks that would be underutilized otherwise. Release times also vary per specialty. Procedures booked far in advance, such as joint replacements, may have release times far in advance of the day of surgery, such as 14 days. Cardiac surgeons may hold their block time until the day before surgery, however, as would burn services.
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4. Proactively avoiding gaps due to equipment problems. One best practice to avoid potential delays and gaps for missing equipment is to hold routine, daily meetings to forecast potential problems for the next day’s caseload. For instance, are there any simultaneous procedures that may require the same piece of imaging equipment? Are any pieces of equipment experiencing technical difficulties or under repair? Identifying these problems ahead of time can help surgeons and their teams avoid a time-consuming setback in the middle of a procedure or block time.

Ensuring surgeons’ preference information and cards are up to date can also help avoid potential delays. By regularly updating surgical preference cards, OR managers can help ensure case carts are thoroughly and precisely prepared for each procedure and clinical team. This saves OR time that would otherwise be spent looking for missing instruments, and it also reduces variable costs by reducing unused supplies.

J.D. Waldman, MBA, MD, professor of pediatrics, pathology and decision science with the University of New Mexico in Albuquerque and author of “Uproot U.S. Healthcare,” says queuing theory can help OR managers plan for potential changes in volume, equipment utilization and other OR patterns. Queuing theory has to do with the mathematical study of waiting in lines, but it involves a closer analysis of resource allocation that can help OR stay ahead of demands. “You can use queuing theory to know what resources you need at 3 p.m. and what resources you need at 3 a.m., because those may be very different things,” Dr. Waldman said.

5. Case start times. Tardiness in the OR is like a snowball rolling downhill. A morning case that begins 30 minutes late has repercussions for the entire day. The total length of tardiness grows larger as the day goes on, since the total duration of preceding cases increases. In his research, Alex Macario, MD, a professor with Stanford School of Medicine, found well-functioning OR suites have a cumulative tardiness of less than 45 minutes per every eight hours.

To curb tardiness to less than 45 minutes per eight-hour block, OR managers should ensure patients’ medical records and other necessary documents are available and complete prior to case start time. They should also determine when patients are told to arrive with precision — not too early, which can dent satisfaction rates, and not too late. Anesthesiologists, surgeons and other clinical team members should arrive on time, as tardiness on the providers’ part can lead to dissatisfaction among the entire team. Finally, ordering surgeons’ cases from most predictable to least predictable, and thereby the longest, can reduce the likelihood of cases running over schedule.

6. Controlling turnover times. Turnovers are different from delays, in that turnovers are less than one hour while delays surpass an hour. Still, lengthy turnovers are a source of significant dissatisfaction among surgeons, who see turnovers as lost OR time that could have otherwise been scheduled for cases. Consequently, many hospitals focus on turnover time reduction to drive OR efficiency, but several experts and researchers say these improvements may not yield significant additional time at the end of the day.

Furthermore, turnover time reductions can also signal unintended consequences related to quality. “Superhuman effort, for example, to rush around on the day of surgery trying to reduce turnover times may be dangerous, stressful and have little financial justification,” Dr. Macario wrote in a 2010 editorial published in the Journal of Clinical Anesthesia. Dr. Macario also said costs associated with turnovers are only reduced if the hospital also reduces its OR allocations and staffing, which could potentially affect clinical quality, sterilization processes and patient safety. Instead, OR managers and clinical staff may be better served by focusing on same-day cancellations, on-time procedure starts, equipment availability and parallel processing to increase efficiency.

10 Latest OR Expansions

Hospitals across the nation are building and expanding their operating rooms in order to increase their capacity. Here are 10 of the most recent OR expansions.

Barnes-Jewish St. Peters (Miss.) Hospital has begun the first phase of its multi-year renovation, which includes the addition of two 600-square-foot operating rooms.

Beaumont Hospital, Royal Oak (Mich.) opened the Suzanne & Herbert Tyler Center for Cardiovascular Interventions, which features a 1,600-square-foot hybrid operating room.

Concord (N.H.) Hospital completed an $11.6 million renovation, which features two new operating rooms.

Fresno (Calif.) Surgical Hospital rebuilt five operating rooms as part of its two-year reconstruction project.

Hammond-Henry Hospital in Geneva, Ill., added a third operating room as part of its recently completed $22 million construction project.

Hoag Memorial Hospital Presbyterian in Newport Beach, Calif., opened the Hoag Heart & Vascular Institute, which includes three cardiovascular operating rooms.

Keesler Hospital, part of Keesler Air Force Base in Biloxi, Miss., opened a $55 million patient tower that includes two new operating rooms.

North Oaks Medical Center in Hammond, La., unveiled a $95 million expansion, which features 14 operating rooms.

St. Luke’s Hospital in Kansas City, Mo., opened a neuroscience institute that features four neurological operating rooms.

Via Christi Hospital in Pittsburg, Kan., broke ground on a 40,000-square-foot surgery center that will include five operating rooms.

Surgical Directions is the nation’s premier surgical services consulting firm. We are led by nationally recognized anesthesiologists and surgical services professionals who passionately help our clients improve their perioperative services through operational and cultural transformation. The Surgical Directions team provides hands-on assistance in organizational design, strategic planning, scheduling optimization, materials and instrumentation management, information systems design, staffing, OR management, physician relations, anesthesia negotiations, and revenue cycle management. Over the past decade, we have successfully helped more than 130 hospitals increase surgical volume, improve surgeon and patient satisfaction, decrease costs, implement perioperative growth plans, and enhance overall perioperative and anesthesia performance.
Keep it Simple

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

At a time when we in healthcare are considering some very sweeping innovations, we need to remember the old axiom: Keep close to your roots. Now, more than ever, we need to keep things simple and not stray from our mission.

I sit on a U.S. advisory board of a European healthcare information technology company that has been introducing its product to the United States. It’s a great product, and at a recent meeting, company executives were telling us about their plans to adapt it for non-healthcare uses. A U.S. hospital executive on the board had a few words of advice at the meeting. Stick to your knitting, he said. Focus on selling its core product and don’t go off on tangents.

I spoke up in agreement. Yes, taking a core product and developing add-on uses is tempting, but you shouldn’t do it when you are entering a market — and maybe not even when you’re established. The goal should be keeping with what you do best. Don’t go running off in different directions because you’ll end up diluting the quality of your core product. The company executives listened and seemed to get the point.

It’s no different for hospitals and health systems. As they come under pressure to make fundamental changes in payment methodology, care delivery and core relationships with patients and providers, the temptation is to search for new fiefdoms and territories to conquer. When everything is being turned on its head, it’s easy to forget your mission and go off on tangents.

I have always been a believer in simplicity. In 1976, when I was named publisher of Modern Healthcare, it was a new opportunity for innovation. The hospital market was about a $600 billion industry, and yet there was no single publication directed to hospital C-suite executives, talking about the business side of running an institution.

That’s the editorial need we saw, and we set about developing the best editorial product we could possibly design. Modern Healthcare became a profitable and popular business news magazine because it stuck to its editorial philosophy of giving C-suite executives a quality business news publication second to none. Over the years, there were temptations to go off in different directions, but the original editorial philosophy always came first.

It’s all too easy to get caught up in your own success and want to experiment with new ventures and new markets. In the process, however, your core product can get lost. In healthcare, for example, the need to rebuild an aging facility can turn into erecting a lavish temple to healthcare. Similarly, efforts to integrate healthcare delivery can morph into an ambitious, majestic plan to hire as many physicians as possible. And the desire to improve negotiations with payors can lead to grand plans to swallow up nearby hospitals and found a healthcare empire.

If you want to get an idea of how hospitals can go wrong, read the book, “Unaccountable: What Hospitals Won’t Tell You and How Transparency Can Revolutionize Health Care.” The author, Marty Makary, MD, is a surgeon at Johns Hopkins Hospital in Baltimore. Reading this book, you’ll be shocked at how far some healthcare executives have strayed from the premise of a hospital’s fundamental reason for being.

It’s easy to lose sight of your mission, whether you’re in the business of taking care of patients, putting up buildings or running a parking garage. The message is simple: Always keep your basic business in mind. Work every day on making things better for your customers. Only when your business is viable and making money should you look around for other possible opportunities. And even then, be careful to not get caught up in the glitz and the infatuation that comes with the sweet smell of success.

Here are a few ways to keep things simple:

1. Reexamine your mission statement. When you take time to seriously reread your mission statement, you have an opportunity to rededicate yourself to the core principles of the organization. If the mission statement doesn’t appeal to you, it might be time to rewrite it so that it reflects what you and your colleagues feel it should say.

2. Remember why you got into healthcare. Quite a few healthcare executives have told me they took the time to sit down and spend time recalling why they entered the healthcare field in the first place. In this way, they found new inspiration in what they do for a living.

3. Identify the key issues. Spend a day or two with your C-suite staff and identify the key issues in your day-to-day work. Remember, your success and the success of the organization is dependent on the skilled performance of your people. They need guidance and direction.

4. Engage in mentoring. Be open to helping anyone that asks for your assistance, which is what we mean by mentoring. As we try to do more with less, mentoring has become a lost art in healthcare, but it is necessary if you want to bring out the very best in your team.

5. Keep your life simple. If you really want to succeed and grow, keep your life simple both personally and professionally. Be disciplined in everything you do and inspire others by your dedication and principles.

6. Stay in circulation. Always be visible and available, within reason. Hospital executives should be readily recognizable to all employees.

7. Tear down the gossip mill. Do not tolerate rumors and character assassination, because they destroy individual initiative and harm efficiency. Gossip is a product of closed societies, like the old Soviet Union. The antidote is to be candid, open and respectful of others.

8. Keep on being modest. Smile and have a sense of humor about yourself! Don’t get too caught up in your personal myth, or you could end up like the emperor with no clothes.

9. Be brief. Keep your comments brief and to the point! People will stop listening when you provide long, convoluted answers to simple questions.

10. Think outside the box. New technology provides new ways to make things simple. For instance, Ian Morrison, a futurist in Menlo Park, Calif., asks why hospital emergency rooms, famous for their long waits, can’t be more like Open Table, the online platform that books restaurant reservations.

This is an upward struggle. The healthcare industry has the habit of making simple issues — life and death, sickness and health, pain and relief — as complicated as possible. We have an elaborate oversight mechanism, complex insurance eligibility rules and convoluted steps of care. As we rethink healthcare, it should be our job to restore its simplicity.

Chuck Lauer (chuckspeaking@msn.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.
Avera, a health system based in Sioux Falls, S.D., plans to acquire St. Mary's Healthcare Center in Pierre, S.D., as well as its affiliate hospital, Gettysburg (S.D.) Medical Center.

Dallas-based Baylor Health Care System and Scott & White Healthcare in Temple, Texas, announced the signing of an agreement to combine their health systems.

Bristol (Conn.) Hospital and Health Care Group announced it signed a letter of intent to combine their health systems.

Gettysburg (S.D.) Medical Center plans to acquire St. Elizabeth Medical Center in Pierre, S.D., as well as its affiliate hospital, St. Francis Hospital an affiliate of EvergreenHealth.

EvergreenHealth in Kirkland, Wash., and Valley General Hospital in Monroe, Wash., approved an agreement to make Valley General Hospital an affiliate of EvergreenHealth.

Faxton St. Luke's Healthcare in Utica, N.Y., and St. Elizabeth Medical Center in Utica signed a memorandum of understanding toward a potential full affiliation agreement.

Geisinger Health System in Danville, Pa., and Lewistown (Pa.) Hospital signed a non-binding letter of intent for a potential partnership.

Nashville, Tenn.-based Hospital Corporation of America, owner of Los Robles Hospital & Medical Center in Thousand Oaks, Calif., completed the purchase of Thousand Oaks Surgical Hospital.

Newark, Ohio-based Licking Memorial Health Systems facilitated an agreement between Licking Memorial Hospital in Newark and the Medical Center of Newark for the purchase of the assets and real estate on MCN’s campus.

The LSU board of supervisors unanimously approved memorandums of understanding for partnerships for three hospitals in the LSU Hospital System: Leonard J. Chabert Medical Center in Houma, La., Interim LSU Public Hospital in New Orleans and Lafayette (La.) General Medical Center.

Columbia, Md.-based MedStar Health completed its acquisition of Southern Maryland Hospital Center in Clinton, Md.

Mercy Health System of Maine in Portland and Eastern Maine Healthcare Systems in Brewer entered into a non-binding letter of intent for Eastern Maine to acquire Mercy Health from Catholic Health East in Newtown Square, Pa., after Mercy Health’s letter of intent to be purchased by Boston-based Steward Health Care System fell through.

Montefiore Medical Center in Bronx, N.Y., reached an agreement to purchase New York Westchester Square Medical Center in the Bronx.

New River Medical Center in Monticello, Minn., selected CentraCare Health System in St. Cloud, Minn., as its affiliation partner.

Prime Healthcare Services in Ontario, Calif., and Saint Michael's Medical Center in Newark, N.J., signed a non-binding letter of intent for Prime Healthcare to purchase the medical center.

Queen’s Health System, which owns Queen’s Health Center in Honolulu, closed its acquisition of Hawaii Medical Center West in Ewa Beach from Honolulu-based St. Francis Healthcare System of Hawaii.

St. Mary’s Hospital in Passaic, N.J., and Ontario, Calif.-based Prime Healthcare Services reached an agreement for Prime Healthcare to purchase St. Mary’s.

Stewart Memorial Community Hospital in Lake City, Iowa, formed a partnership with Iowa Health System in Des Moines.

Sinai Health and Holy Cross Hospital, both based in Chicago, received approval from the Vatican and the Illinois Health Facilities and Services Review Board for their planned merger.

San Francisco-based UCSF Medical Center, including its UCSF Benioff Children’s Hospital, and Children's Hospital & Research Center Oakland (Calif.) signed a formal letter of intent to develop an affiliation.

UC Davis Medical Center in Sacramento and Dameron Hospital in Stockton, Calif., agreed to form a joint venture.

Houston-based University General Health System closed its purchase of South Hampton Community Hospital in Dallas as well as an adjacent, 23,000-square-foot medical office building.

University of Maryland Medical System in Baltimore and Catholic Health Initiatives in Englewood, Colo., signed an asset purchase agreement in connection with St. Joseph Medical Center in Towson, Md.

University of Pittsburgh Medical Center is expected to enter negotiations to acquire Altoona (Pa.) Regional Health System.

Venice (Fla.) Regional Medical Center formed a strategic alliance with University of Florida & Shands Healthcare, both in Gainesville, Fla.

Westchester Medical Center in Valhalla, N.Y., and New Rochelle, N.Y.-based Sound Shore Health System made the first steps in forming a corporate merger by signing a memorandum of understanding, allowing them to pursue exclusive talks.

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www.beckershospitalreview.com/4th-annual-beckers-hospital-review-meeting.html
KentuckyOne Health in Louisville named Melvin Alexander, CPA, MBA, as CFO.

John Brennan, MD, CEO of Newark (N.J.) Beth Israel Medical Center, decided he will remain head of NBIMC, turning down an offer to become CEO of Cleveland-based MetroHealth System.

Henry Ford Wyandotte (Mich.) Hospital named Denise Brooks-Williams president and CEO.

William Brown, FACHE, was named CEO of West Suburban Medical Center in Oak Park, Ill., in addition to his role as CEO of Westlake Hospital in Melrose Park, Ill.

Sunrise, Fla.-based Sheridan Healthcare named John Carlyle CEO.

Patrick Christiansen, PhD, was named CEO of Inova Fairfax Medical Campus in Falls Church, Va.

Anthony Cooper was named CEO of Elmira, N.Y.-based Arnot Health, effective Dec. 31, 2013.

Pamela Delagardelle, RN, was named president and CEO of Waterloo, Iowa-based Allen Health System.

Riverside, Calif.-based Parkview Community Hospital’s CEO Doug Drumwright announced plans to resign.

Duane Erwin, president and CEO of Aspirus, a non-profit health system in Wausau, Wis., announced plans to retire at the end of July.

Don Hudson, Mercy Folsom (Calif.) Hospital president, retired and was replaced by Michael Ricks.

Sisters of Charity of Leavenworth Health System ousted the CEO of Saint John’s Health Center in Santa Monica, Lou Lazatin. Saint John’s COO Eleanor Ramirez was also removed from her post.

Sister Sheila Lyne, RSM, announced plans to retire as president and CEO of Mercy Hospital & Medical Center in Chicago.

Health Central Hospital in Ocoee, Fla., named Jennifer McCarthy COO.

Chicago-based Presence Health CFO John Orsini resigned.

Jim Sexton, CEO of Henry Ford Wyandotte (Mich.) Hospital, retired.

Redmond Regional Medical Center in Rome, Ga., named Beemal Shah COO.

Roger Spoelman, president and CEO of four-hospital Mercy Health Partners in Muskegon, Mich., became the regional president and CEO of Trinity Health’s West Michigan Region.

Richard M. Sukenik, CPA, MBA, CHFP, CGMA, was named vice president of finance and CFO of Windber (Pa.) Medical Center.

Catholic Health Services of Long Island in Rockville Centre, N.Y., named Richard J.J. Sullivan, Jr., president and CEO.

The University of Arizona Health Network in Tucson named Michael Waldrum, MD, MS, MBA, president and CEO.

Chattanooga, Tenn.-based Erlanger Health System’s COO and CNO, Lynn Whisman, and Erlanger Health System Foundations’ president, Betsy Chapin Taylor, both stepped down.

Lori Van Zanten, FACHE, was named CEO of the Providence Yamhill Service Area, which includes the Providence Newberg (Ore.) Medical Center.
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