SCOTTSDALE INSTITUTE

INSIDE IE EDGE

August 2007
Volume 13, Number 7

Stark, EHRs and Physicians: A Snapshot

EXECUTIVE SUMMARY

When the Stark II anti-kickback guidelines were relaxed last fall, many hospitals and health systems won what was for them a long-sought opportunity to facilitate adoption of EHRs by community physicians. Besides helping achieve the troika of quality, safety and efficiency of care, implementing EHRs in physician offices literally enhances the link between two key players in the healthcare community.

In a nutshell, loosening of Stark allows hospitals to subsidize up to 85 percent of the cost of EHR software and implementation for physicians. Given the slow penetration of EHRs in physician offices due to cost and un-economies of scale, this move represents a potentially momentous shift in the adoption of IT in healthcare. Also, since most care is ambulatory and most patient information resides in physician offices, the vision of a true integrated medical record is impossible without automation of clinical information outside hospital walls.

But the obstacles are daunting. If herding cats is the traditional analogy for the difficulty of organizing physicians, imagine trying to wire them at the same time. As in any IT implementation, cost and technology (including standards) are just the first hurdles—and not necessarily the hardest ones. Workflow redesign and the investment required to maintain EHRs loom large. This issue of IE provides a snapshot of how a few health systems are facing these challenges in the aftermath of Stark revision. It's clear we're still very early in a process that has the potential of substantially accelerating the interconnectivity of healthcare.

Open up the portal

Hospitals and health systems have several options when it comes to providing types of EHR connectivity to community physicians.

"There are at least four strategies that hospitals can undertake," says Keith MacDonald, a research director at FCG's emerging practices unit in Boston. "A first step is for hospitals to launch web-based physician portals to share information like laboratory test results. Doing so is a no-brainer but it's not an EHR, of course—it's hospital-focused data," he says. Still, this is a low-cost, high-value way to introduce physicians to the benefits of accessing data remotely. Because portals can be an early, positive experience, they can help ease the transition to EHRs.

The next step is for hospitals to make their enterprise EHRs available to their own employed physicians. Making the ambulatory EHR available to affiliated independent physicians—for which there will be a fee—is the only way among the four, however, to achieve true integrated patient data in the community because it is a true, shared record leveraging a single database. Whether for its own or independent physicians, says MacDonald, this strategy can represent a completely new line of business for hospitals because until now most hospitals have been using and supporting their EHR in an inpatient setting but not outside their walls.

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WELCOME NEW MEMBER

Lifespan

The Scottsdale Institute is proud to welcome new member Lifespan, a not-for-profit healthcare system, based in Providence, RI.

Lifespan, Rhode Island's first health system, was founded in 1994 by Rhode Island Hospital and The Miriam Hospital. A comprehensive, integrated, academic health system, Lifespan's present partners also include RI Hospital's Hasbro Children's Hospital, Bradley Hospital (the nation's oldest psychiatric hospital for children) and Newport Hospital.

Lifespan hospitals combined rank 9th in the nation for research and training grants from the National Institutes of Health. It has also been recognized nationally for being at the leading edge of technology in healthcare, winning the *100 Most Wired, 25 Most Wireless, CIO 100 and CEO IT Achievement* awards.

Lifespan has 11,140 employees and 2,677 affiliated physicians with 1,155 licensed beds.

Welcome to Carole Cotter, CIO, Mary Cooper, MD, JD, Chief Quality Officer, Reid Coleman, MD, Chief Medical Information Officer and the entire Lifespan team.

Keith MacDonald, research director, Emerging Practices, FCG, Boston

As a result, this approach can mean that the hospital becomes an application service provider or ASP host for local physicians. "In effect they can serve as the outsourcer for a particular vendor in that community. For example, Premier Health Partners, a health system in Dayton, Ohio, is now the Epic provider in their community," he says.

Notwithstanding the fact that Stark now allows a health system to pay up to 85 percent of the cost of software and implementation, MacDonald says most if not all pay much less, between 15 percent and 50 percent. "Sometimes that's enough of an incentive for a physician practice. We haven't seen any hospitals paying anywhere near the full 85 percent. It's closer to 15 percent—because it's an expensive undertaking," he says.

Host with the most

A third option is a pure ASP model, in which a health system hosts not an ambulatory version of its own EHR—although most HIT vendors have solid ambulatory EHRs—but a "pure" ambulatory EHR such as one made by Allscripts or NextGen. "One advantage is that those are products well-known to office-based physicians," says MacDonald, "and they have extensive experience supporting ambulatory physician practices."

One big challenge associated with hosting a dedicated ambulatory EHR, however, is that clinical data can't readily be shared with the hospital's core HIT vendor because they're separate products. Still, many organizations are pursuing this strategy. "You can integrate those products but not at a level necessary for detailed clinical disease management and reporting," says MacDonald.

A fourth option is to use newly available integration tools. These "hosted integration engines," from companies like Novo Innovations, Mobile MD and Accenx, do much of the work of traditional interface engines except that they're hosted remotely by a third-party vendor rather than by the hospital. One key advantage is that in a community with multiple EHR vendors—each of which releases software upgrades at a different time—it's the job of the integration vendor (not the hospital or physician practice) to update the associated interfaces. While MacDonald says this approach still represents an early market, it could result in a new era of integration. Once vendors work out the specific details of integration with a particular EHR product, they can replicate that approach anywhere else.

Oh, yeah, the practice management system

The challenges of providing EHRs change depending on the particular model. For example, hospitals must grapple with the question of what to do with a physician office's practice management system, which it may have been using successfully for years. If the physician practice wishes to keep its practice management system, staff must reenter data in the practice management system once the patient visit has been completed. A hosted EHR may force practices to undertake workarounds or elect a new practice management system since no hospital is likely to build special interfaces to all of those systems.

MacDonald says there isn't a hospital in the country that isn't trying to figure out what to do in terms of subsidizing physician EHRs. "It's a big undertaking. It's hard enough to implement CPOE and EHRs when you *own* these physician practices. Trying to implement such a system for community physicians that are *affiliated* with the hospital is an even greater challenge—particularly if it's not a vendor system they've selected themselves. With such a high-visibility community initiative, you don't want to anger physicians and make alignment with them more difficult. It's one thing to provide poor wait times for lab results, but if you disrupt a practice's lifeblood and physicians' day-to-day workflow, the risks increase dramatically."

Traversing EHRs in Michigan

After discussing the issue with physicians in the community for several months, Munson Healthcare in Traverse City, Mich., launched a program to subsidize EHRs for those independent physicians in June. Munson, a seven-hospital system serving the 32 counties of northern Michigan, is initially focusing the program on the 400 independent physicians who use 400-bed Munson Medical Center in Traverse City, a well-heeled resort town at the base of Grand Traverse Bay.

Chris Podges, CIO, Munson Healthcare, Traverse City, Mich.

"It's part of our strategic plan to create greater connectedness between facilities, consumers and providers," says Chris Podges, Munson Healthcare's CIO. "We're the only provider in town and the only tertiary care facility in our service area. Because of that, our board feels we have an outright obligation to provide the best care we can to the patients we serve and an important aspect of that is giving providers the best information available about the patients they see."

Podges estimates that up to 60 percent of clinical information resides in physician practices, putting a great premium on the health system's ability to integrate clinical and demographic data from ambulatory and inpatient settings. Through the subsidy program Munson hopes to incentivize physicians to adopt EHRs, "because physician adoption of EHRs has been going pretty slow," he says.

Munson Medical Center has selected three EHR vendors—NextGen, A4 and Misys—which it will host remotely for clinics based on the following criteria:

- A practice with five or more providers will receive a subsidy of 40 percent of the license fees for EHR software.
- A practice with less than five full-time physicians will receive a subsidy of 40 percent of license fees and implementation costs.
- Munson will also subsidize 85 percent of the $2,500 per physician, per year hosting fee.

Let the market dictate

"We've been hosting the Misys practice management system for about 60 community clinics for almost a decade. Some of those were interested in the Misys EHR, which was evaluated by an ambulatory EHR committee. We also relied on industry analysts. NextGen and A4 happen to be good products used by several big clinics in town. We had a small set of requirements like support and interoperability, and so we wanted to keep the number of preferred vendors to just a few, but we largely let the market dictate who the vendors would be," says Podges. Those vendors had also expressed an interest in fostering integration among their products.

"With such a high-visibility community initiative, you don't want to anger physicians and make alignment with them more difficult. It's one thing to provide poor wait times for lab results, but if you disrupt a practice's lifeblood and physicians' day-to-day workflow, the risks increase dramatically."

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September 14
Hosting Community-based Physician EMRs: Five Years in the Making at Partners
- Cindy Bero, CIO, Partners Community Healthcare, Boston

October 1
Seton Outpatient Case Management Program: An Intensive, Comprehensive, Clinical Case Management Mode
- Pat Beal, Licensed Clinical Social Worker and Outpatient Case Operations Manager, Seton Healthcare, Austin, Texas
- Vanessa Hernandez, Yvettte Lopez, Kaylynn Schrandt, Chastity Shugart, Meredith Smith, and Erin Taylor, all Licensed Master Social Workers and Outpatient Case Managers, Seton Healthcare, Austin, Texas

October 4
Provena Health Multi-Site BCMA Planning Project: Key Design Decisions and Lessons Learned
- Jim Witt, RN, MBA, system vice president, Clinical Integration, Provena Health, Mokena, Ill.
- David Troiano, RPh, MSIA, senior manager, First Consulting Group, Long Beach, Calif.

more events on next page

Getting the word out to physicians is easier when you're the only hospital, but it still requires a multi-channel approach. "Traverse City is a fairly small community and we market the heck out of our strategy. We also work in concert with the vendors who often have a better sense of what a physician office needs," he says. A small ambulatory applications unit within Munson's IT department handles calls from community clinics interested in the subsidy. The message was also shared through the Munson corporate communications department's physicians newsletter called MedNews. And then there are one-to-one conversations. "We sometimes just ping a hot list of docs who are nearing an EMR decision. And we've done medical staff surveys. It's a little bit of everything," says Podges.

To date, Munson has signed up five clinics, ranging from a two-physician rural practice to a 15-provider multispecialty clinic. Three clinics are up on practice management and two are partially up on EHR. "We've clearly generated some interest in the community—about eight clinics are interested," he says. "The subsidy has helped. It's the spirit of the times. If we'd done this four years ago I don't think we'd gotten a phone call. There's so much interest now," he says.

The biggest obstacle, says Podges, "is individual practices making individual decisions. We're providing 40 percent of the cost, so the practices still have to come up with a significant amount of money. Clinics have to be dedicated to the idea, have the financial resources and have picked an EHR from the three preferred vendors. Smaller family practices are going to be more challenged. So our pace of progress will be dictated by individual clinics making individual investment decisions."

One of the biggest challenges is that clinics underestimate the level of effort and commitment required to redesign the workflow, and that has Podges maintaining a flexible strategy. "Vendors are good at implementing software, but not at redesigning workflow. Unlike some health systems, Munson opted not to be responsible for implementation or support because we wanted to be seen as facilitating this transition, not dictating it. We may revaluate the need for workflow expertise and re-design help as physicians implement the software and try to optimize their investment. We're installing software in an environment where physicians are new at it, we're new at it and the notion of community integration is still mostly uncharted territory." That means stay tuned.

Hackensack University Medical Center

With more than 90 percent of its 1,400 affiliated physicians in independent practices, Hackensack University Medical Center, a 791-bed tertiary facility in Hackensack, NJ, faces a big job in just assessing how to proceed vis-a-vis Stark. That's why a month ago it launched a two-page ambulatory EHR survey of those physicians, asking about EHR usage, likes and dislikes, future plans, and if they would consider subscribing to one hosted by HUMC. (See table next page.)

Gerard Burns, MD, CMIO, Hackensack University Medical Center, Hackensack, NJ

"So many docs call me all the time," says Gerard Burns, MD, CMIO at HUMC. "They know they're going to have to eventually adopt the EHR, but they don't have the knowledge base, whether about vendors, servers, customized or non-customized products, and how to link them. They don't have the skill

set," he says, adding that anecdotal evidence tells him doctors are interested. "They're intrigued by us hosting an EHR subscription service."

HUMC has made the survey available electronically on its physician web portal, in paper in the physicians' lounge and blast-faxed to physician offices. "We chose to cover all the bases. Physicians just need to fill it out once. We ask them their name and size of their physician practice, so we have a way of getting back to them," says Burns.

HUMC PHYSICIAN EHR SURVEY RESULTS
• 82% are NOT currently using an Ambulatory EHR
Of those WHO ARE using an Ambulatory EHR (users can select more than one answer)
• 81% believe it makes the office visit more efficient
• 48% believe it makes patient care safer
Of those NOT using an Ambulatory EHR
• 33% are learning about EHR options and available systems
• 32% are thinking about using an EHR within the next several years
• 17% are NOT considering using an EHR in the office at this time
• 16% are actively pursuing purchase of a specific system within the next year
Reasons for not using an Ambulatory EHR (users can select more than one answer)
• 80%—cost
• 40%—maintenance of servers, workstations etc.
• 40%—lack of expertise in this area
• 35%—overwhelmed—too many options
• 28%— FTEs—need for a system administrator
If HUMC were to offer an Ambulatory EHR
• 72% would consider subscribing to it
• 86% believe that it would be useful to be able to access the office EHR from HUMC (i.e. while rounding or seeing patients in the ETD)
NOTE: As of August 22, Hackensack University Medical Center had received 152 responses to its medical staff survey regarding HUMC subsidizing physician ambulatory EHRs.

He says physician practices of 10 or more would likely be able to justify the investment in an EHR, however for a two or three-doc practice the cost is too high to justify. Early indications are that a subscription fee of $200 to $300 a month is acceptable.

Jersey RHIO wanted

Burns believes strongly that healthcare interconnectivity is mission critical for the state. "New Jersey is extremely densely populated, and people have multiple options. There are 85 acute care hospitals and a multitude of doctors. It's very competitive, fragmented, without much collaboration and there's no single dominant insurer like Kaiser. It's the perfect place to build a RHIO," he says.

"We're doing the citizens of New Jersey a disservice [by not having connectivity].

Upcoming Events continued

October 9
Palm Beach County Community Health Alliance Case Study: Technology Enabling Access to Care
- Robert Olmedo, Director of Technology, Palm Beach County Community Health Alliance, Palm Beach, Fla.

October 11
Digital Hospital
- Baldur Johnsen, HP, Palo Alto, Calif.
- Ben Wilson, Intel, Santa Clara, Calif.

October 18
Intermountain Healthcare Enterprise Data Warehouse Case Study
- Steven Barlow, manager, Enterprise Data Warehouse, Intermountain Healthcare, Salt Lake City

October 24
How Hospital CIO's Can Embrace Translational Informatics
- Keith Strier, JD, principal, Deloitte Consulting LLP, San Francisco
- Mitch Morris, MD, principal, Deloitte Consulting LLP, San Francisco

October 25
Business Intelligence
- Paul Vosters, practice area leader, Health & Life Sciences, Hewlett-Packard Information Management, Palo Alto, Calif.

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"Plus, if you buy into the template, you're not alone. You have a network of people to share best practices with. There are lots of wonderful theoretical benefits."

We have an EHR, but we can't see what happened to the same patient at a clinic or hospital down the street. Every patient should have a complete allergy list, medication list and problem list. How cool would it be if all 1,400 docs used the EHR so when patients are referred from a cardiologist, everyone would be working off the same data. If a patient showed up in the ED you could pull up their ambulatory EHR for optimum, safe and non-redundant care. Plus, if you buy into the template, you're not alone. You have a network of people to share best practices with. There are lots of wonderful theoretical benefits," he says.

HUMC's EHR initiative and a RHIO—or national health information infrastructure—have the same overall goal of enabling every person to have a comprehensive EHR by 2014. "I see it as working from both ends of a fuse. What I can do is make sure information from HUMC is electronically available. We're already filmless and our transcription is digital. Our electronic clinical data is solid and accurate and enables clinicians to do the right thing. You have to work it from both ends and meet in the middle somewhere," he says.

Fair market value

In the hotbed of Twin-Cities' healthcare, North Memorial Medical Center stands out as an independent community hospital, unaffiliated with any large integrated health system or health plan. "The majority of our referring physicians are affiliates, so that makes the whole EHR effort more challenging than for other hospitals in the marketplace," says Pat Taffe, CIO at Minneapolis-based North Memorial. "We can't just say you're going to put in an EHR."

In 2005 before Stark was loosened, North Memorial management went to its board of

North Memorial

Pat Taffe, CIO, North Memorial, Minneapolis

trustees with the recommendation that as a community hospital it should offer its EHR to affiliated physician practices at fair market value. "We brought in consultants to help us understand the cost to an average physician practice to implement an electronic health record system. We then went to the board with a recommendation that we would charge physicians the low end of fair market value, which was less than what it would cost us to deploy our fully integrated system. North Memorial covered the gap between the two costs, which our legal counsel defined as reasonable community benefit," says Taffe.

"Clinics weren't standing in line to sign up. While it generated a lot of interest, the cost of entry is pretty high, even at the low end of fair market value. The barrier was pretty big," he says.

When Stark was loosened in October 2006, Taffe saw it as an opportunity to spread deployment of EHRs to physicians who couldn't afford them. "There are some independent practices out there who have visionaries on the leading edge and who have bit the bullet and invested in EHRs," he says. Even a few one or two-physician offices with a computer geek have developed EHRs. However, the problem becomes one of interoperability among those siloed systems.

Rolling the dice

Cost is also a huge hurdle for donors. "Who can afford to give it away at an 85 percent

discount? Most hospitals are struggling. How much is it worth to have connectivity to all affiliated physicians? How do you put a price tag on that? Even though it's a great concept, we've really struggled with the funding issue," Taffe asks.

Still, despite the angst, North Memorial management felt they couldn't afford not to implement an EHR subsidy program for their affiliated primary care physicians. "As time goes by, everybody becomes more interoperable and connected. We've conducted a lot of internal discussions and decided we are going to offer the Stark discount to our affiliated primary care physicians. This is still pretty new territory and others are still trying to figure it out," he says. "I sure wish there were more out there who had done this already."

North Memorial's first affiliated physician group—46 clinicians, including 11 faculty physicians and 35 residents—went live August 15. "The physician group decided they wanted to go totally wireless and put in all their own wireless equipment. We provided access over a secure internet connect to the EHR application hosted at North Memorial," says Taffe.

Next steps are to continue to roll out the EHR to affiliated physicians. That effort could be accelerated by the fact that North Memorial is in the process of building a new hospital in suburban Maple Grove, Minn., which is slated to open Dec. 30, 2009. Maple Grove Hospital will open as a 90-bed facility and will expand to as many as 300 beds when needed. That's not all. In September, North Memorial is opening a new 90,000-square-foot medical office building to be followed in December by a new ambulatory center. Both facilities will be adjacent to the new Maple Grove Hospital. As a result, many affiliated physicians are expanding their practices and getting wired with an EHR at the same time.

In its agreement with physicians North Memorial has stipulated an IT-support component designating Super Users at each clinic as the first line of defense, the go-to persons for questions on clinical or back-office applications. Super Users also train new staff at the clinics or offices. Questions too difficult for onsite resolution are triaged to North Memorial's IT service desk where they are further triaged as levels one, two or three, the latter possibly referred to experts at the vendor.

Taffe, like Burns, sees physician EHRs in a continuum that ultimately may find expression in a regional health information exchange. "We have an interesting dynamic here in the Twin Cities. Epic has a significant presence at eight healthcare systems in Minnesota and there's a very active Minnesota Epic users group. Discussions have arisen among the Minnesota Epic users group members about collaborating with Epic to create their own interoperability or mini-RHIO. We've agreed not to compete on the technology. If the eight Minnesota Epic healthcare systems can put the pieces together and exchange information among themselves, the next step would be to plug into a RHIO to pull the final pieces of the puzzle together."

NYC Medicaid providers get EHRs

Other physician-EHR initiatives are underway.

New York City's public health department has launched a two-year program that will give EHRs to high-volume Medicaid providers, those where more than 30 percent of patient encounters are either Medicaid or uninsured.

Farzad Mostashari, MD, assistant city health commissioner for the City of New York, is quick to emphasize that the mission

"This is still pretty new territory and others are still trying to figure it out. I sure wish there were more out there who had done this already."

of this initiative, called the Primary Care Information Project (PCIP), is to increase the quality of care in medically underserved areas through health information technology, not to provide EHRs to physicians.

[Mostashari presented an SI teleconference on the topic "New York City Gives EHRs to Medicaid Providers" on July 23, 2007. The audio presentation and slides are available to members on the SI website. Click on "Teleconferences" in the left column under "Members Only."]

However, the three-pronged PCIP roadmap envisions three interlocking citywide networks, including an EHR network, a quality improvement network and a health information exchange network. After an evaluation process that included an RFP based on CCHIT requirements, the department selected eClinicalWorks as the EHR vendor. "It's a nice web-based, three-tier architecture that has lots of appealing technology," says Mostashari.

The goal is that all NYC Community Health centers will have EHRs by 2009. That includes 648 providers, 500,000 patients, half of whom are Medicaid and a fifth who are uninsured. Other small physician offices with low EHR adoption rates will be targeted as well. Outreach staff have developed a "Public Health Detailing Kit" with educational materials targeted to providers, office staff and patients.

Besides caring for underserved populations, clinics must participate in public health goals like indicator reporting and quality improvement and interface with other public health entities such as school health departments. They must also put skin in the game. "The danger is that providers underestimate how hard it is to adopt EHRs. So, we're asking for an in-kind contribution plus a $4,000 contribution," says Mostashari. They must also assume all ongoing costs after a two-year testing phase.

"The danger is that providers underestimate how hard it is to adopt EHRs. So, we're asking for an in-kind contribution plus a $4,000 contribution," says Mostashari. They must also assume all ongoing costs after a two-year testing phase.

What providers get in return are licenses to "NYC Build" eClinicalWorks, common interfaces, on-site training and quality improvement technical assistance. They also get predictable and relatively low maintenance and service costs estimated to be less than $1,500 per FTE provider per year.

Mostashari estimates that unsubsidized providers will break even after two years; subsidized ones after only a year. In September 400 private providers will become the first wave to go live. He anticipates no physician resistance. "So far we're working with early adopters. We're not trying to convince people who don't want to do this."

Conclusion

The world according to Stark post-October 2006 will be measured, at least for awhile, in small steps as hospitals, health systems and physicians negotiate its new landscape. The obstacles are daunting: Funding, EHR products, interfaces and interoperability, practice management systems, training, ongoing support and redesigned workflow constitute some of the main ones. If it sounds like the job of running an IT department, that's probably accurate, sans the advantage of ownership of the provider practice using the EHR. This is the antithesis of plug-and-play. As Farzad Mostashari, MD, described so eloquently in his July 23rd teleconference (see above), "EHRs on their own do not improve the quality of care. Even with workflow changes, there's still a lot of work to be done."

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Charleston Area Medical Center, Charleston, WV

Children's Hospital of Pittsburgh, PA

Children's Hospitals & Clinics, Minneapolis, MN

CHRISTUS Health, Irving, TX

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