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INSIDE EDGE

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Meaningful Use 2.0: Health Systems Face Many Moving Parts

EXECUTIVE SUMMARY

As health systems complete Stage 1 and plan for Stage 2 of Meaningful Use less than a year from now, two solid years into CMS's HITECH program, it's a good moment to take stock of where some providers are. Broadly speaking, Meaningful Use Stage 1 is about proving you can use an EHR; Stage 2 is proving you can get information out of the EHR; Stage 3 is proving you can improve outcomes using the information in an EHR.

Some leading health systems have taken Stage 1 in stride, confident in their early implementation of an EHR. Those organizations are also likely to be less intimidated by Stage 2, which ramps up threshold requirements while stretching providers in their information-exchange capabilities. Other health systems are scrambling to implement EHRs across the enterprise and continuing to wrestle with Stage 1 requirements. All strategies should work back from July 1, 2014 which is the last date for hospitals to attest to Year 1 of Meaningful Use and avoid 2015 Medicare penalties.

Large health systems have perhaps the biggest challenge in addressing the complex task of meeting Meaningful Use requirements for the three stages—with diverse hospitals and physician groups in sprawling regions and sometimes multiple states with variegated resources and infrastructures—all while facing the need to convert coding to ICD-10 and prepare for HC reform. This effort requires a strong combination of vision, management, technology and leadership.

A $9-billion bet so far

Half of U.S. hospitals have attested for Stage 1 Meaningful Use and the federal government has paid out about $9.2 billion to healthcare organizations for achieving Meaningful Use, according to Laura Kreofsky, PMP, CPHIMS, principal for discovery and development at Impact Advisors, a Chicago-based healthcare-IT consulting firm. She leads the firm's Meaningful Use services and also serves as program director for Meaningful Use at Sacramento, Calif.-based Sutter Health with Sean Gaskie, MD, whose comments follow.

"Most of Impact Advisors' clients are in Stage 1, Year 2," she says. "The few that attested in 2011 for Year 1 bought themselves an extra year. Yet, many organizations will be attesting for Stage 1 Year 1 in 2013 and are feverishly working on getting their EHR in place."

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Laura Kreofsky, Principal, Discovery & Development, Impact Advisors

If you think bigger organizations can leverage economies of scale for Meaningful Use, think again. Large IDNs may have to manage Meaningful Use for hundreds of providers and numerous hospitals at different points in EHR adoption and years and stages of Meaningful Use.

"You need resources, tracking tools and very good communications," Kreofsky says, because a hospital at one stage might think Meaningful Use directives pertain only to hospitals at another stage. "Organizations must drill down another level to understand why Hospital A is reporting and we're not, or vice versa. Ultimately, Meaningful Use causes anxiety for staff throughout an organization because it touches everybody."

Sutter Health, a 24-hospital system serving northern California, must track 1,800 providers—part of the 5,000 members of the Sutter Medical Network—for five or more years. And, those years aren't always sequential. A provider might miss a year and be docked to a lower tier of Meaningful Use incentive payments. (Medicaid does not dock providers in the same way.)

Administrative headache

That Meaningful Use can be a major administrative challenge for large delivery organizations is partly because CMS originally designed Meaningful Use for single providers and single hospitals—a bias that plays out when developing processes, policies and Meaningful Use attestation plans. "On the administrative level, that's where your pain is," says Kreofsky.

One lesson learned is that it's critical to pay attention to CMS's FAQs regarding Meaningful Use. "They've adjusted their approach and we've had to adjust things in flight," she says. A case in point: immunization registries, a public-health component of Stage 2. CMS hadn't anticipated the complexity involved in requiring a large health system to demonstrate data submission to a public health registry from every physical site of care. While a two-clinic provider might have little trouble meeting this requirement, for Sutter Health it means submitting data from 220 care sites, an unnecessarily burdensome task especially considering all Sutter sites use the same integrated database/EHR.

Looking ahead to Stage 2, things aren't going to get any easier. At least one major EHR vendor believes Stage 2 will require twice the effort of Stage 1, says Kreofsky. "This is not just an upgrade of the EHR, but much more integral to workflow, communications, and data interoperability, and many delivery organizations have yet to focus on that reality."

As the Stages advance, reporting for Meaningful Use only gets tougher. Regulations are complex and EHR vendors are scrambling to build and configure systems that not only extract the right data but ensure it's clean and standardized to begin with.

"Reporting is one of Sutter Health's biggest Meaningful Use challenges. Reporting is hard because the regulatory requirements are so nuanced the Sutter Health database is huge, and the report configuration is complex. A CIO told me as long as 18 months ago that 70 percent of the resource time required to achieve Meaningful Use was spent on getting the reports right, and I'd say that's a solid estimate of what it's taken at Sutter Health," she says.

Hidden gotchas

CMS has modified about 10 measures in Stage 1 per the final Stage 2 Rule. In many cases, these changes were made so health systems can "work smarter, not harder" and to ease the transition from Stage 1 to Stage 2. For example, Stage 1 stipulates providers maintain medication, allergy and problem lists for a certain 80 percent of patients. Stage 2 folds those requirements into the single summary-of-care record to be produced at transitions of care (TOCs). "CMS will no longer measure you on components, but on bringing value to the patients and providers. CMS is trying to focus on the end result and not process, to get the most bang for the buck," says Kreofsky.

Still, such simplifications can hide gotchas. For example, Stage 1 requires test of a health information exchange (HIE). While that requirement goes away in 2013, the requirement to share summary records at TOCs electronically as early as 2014 implies actual use of HIE capabilities.

"Stage 2 across the board does a lot to enforce good clinical practice," she says. Stage 2 also drives the industry toward a more standardized clinical nomenclature. "Medication reconciliation is huge in itself."

In addition, Stage 2 puts more emphasis on patient engagement. "We're moving beyond traditional parameters. Portals and PHRs will become more important. There will be a thinning membrane between patients and providers, between my PHR and your EHR. Looking ahead, the proposed Stage 3 rules suggest patients will be able to edit or input information into an EHR. The move is clearly toward patient engagement and the provision of high-value information in a manner useful to them," says Kreofsky.

Building bigger machinery

Sean Gaskie, MD, Sutter Health's physician director of clinical analytics and decision support, acknowledges the health system is very early on the Stage 2 journey. "CMS just released the specs for quality measures two weeks ago. We're still focused on completing attestations for Stage 1," he says. Because Stage 2 requires capture of new data elements and adoption of new workflows, the health system has to wait while its EHR vendor, Epic, works diligently to achieve certification and release tested functionality to support Stage 2 clinical workflows.

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Sometimes it hurts to be a leader. Sutter Health was an early EHR adopter—it began implementing Epic in 1998 in three physician foundations simultaneously and allowed them to

"Portals and PHRs will become more important. There will be a thinning membrane between patients and providers, between my PHR and your EHR."

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- Jared Rhoads, senior research specialist, CSC
- Karl West, chief information security officer, Intermountain Healthcare

continued on next page

evolve somewhat autonomously, as their business needs and competitive environments warranted. With more ambulatory implementations and an accelerating hospital go-live schedule across its five regions uncovering even more variability among workflows and practice "cultures," the organization has doubled down on standardizing data architecture and nomenclature, launching a Master Data Management initiative to institute an upstream data dictionary to ensure consistent definitions for conditions like hypertension and diabetes.

"It took us a long time because everyone gets used to their own nomenclature. We're trying to get to one common build," he says. To date, Gaskie and his team have succeeded in achieving a single EHR version at all ambulatory sites. More tough work lies ahead. "Now it would be nice to have one set of workflows."

A disadvantage at such a large organization is that some sites innovate faster than others—sometimes faster than the platform vendor. "We were ready to do a lot of things before Epic functionality was released. So, we had to tweak their software. Such customization greatly complicates updates and system upgrades. We would be more nimble and have the resources to implement more features in each Epic release, had the 'model system' been available. Maintenance of custom functionality, like non-value-add workflow variability, has significant opportunity cost," says Gaskie.

Sutter Health is mapping Stage 2 while its regional management teams work to complete attestation for the 85 percent of Sutter's 1,850 ambulatory doctors who are eligible for Year 1 incentives. "We believe 90 to 95 percent will succeed in 2012. For another 5 percent, it's coming way too soon. We still need to get another 200 eligible providers to attest. One of the big wins in Stage 2 is the ability to bulk upload attestations," he notes.

Meaningful Use presses clinicians to use the EHR that's in place, but has not yet been used to its full potential. "Stage 2 will push us hard on patient engagement and interoperability. The healthcare environment demands better access and affordability. Simultaneously, ICD-10 will make life more complicated. HIEs are getting more vibrant, and will take a prominent role in enabling the interoperability we will need to deliver coordinated care more proactively and accountably," says Gaskie.

Sutter Health's biggest challenge in addressing Stage 2 arises from a key lesson of Stage 1: to engage frontline executive leaders more deeply in Meaningful Use, an initiative that is often peripheral to their attention in a widely distributed organization where IT build and configuration is done by a centralized IT department and where semi-autonomous management structure varies by region and by affiliate.

"On the ambulatory side we've had pretty consistent engagement from the beginning. On the hospital side we were meeting all our thresholds early on, and didn't feel such urgency to rally the troops. We could have done a better job engaging affiliate thought

leaders, especially the nurse executives and bedside nursing staff who have so much insight into workflows and documentation challenges," he says.

Accountable MU

Stage 2's thresholds will be more challenging, and hospitals will be unlikely to meet them all without effective local leadership. "In Stage 1, we didn't put together a model of accountability to reinforce all the workflow changes and incentivize leadership to prioritize adoption and improvement," notes Gaskie.

The toughest objective, however, may be the patient-engagement requirement and the need for patient messaging. "We're going to be more accountable for our patients' behavior. This may pose a particular problem for ambulatory sub-specialists—are our dermatologists and orthopedists eager to receive messages from 5 percent of their patients?" he asks.

While Sutter Health has achieved solid uptake of its patient portal, that strategy is still too passive for Meaningful Use Stage 2, which requires patient-initiated secure messaging to all eligible providers—including sub-specialists. One strategy may focus on soliciting post-intervention functional status reports from patients, who are likely to welcome their provider's concern and find value in returning a pertinent questionnaire. The provider, in turn, would benefit from this outcomes data.

"Meaningful Use has helped us improve care directly, by emphasizing more consistent use of the Problem List and other tools to communicate and coordinate care of individuals and populations. And, as intended, Meaningful Use is accelerating our evolution to a safer and more seamless system of demonstrably effective health care."

[Members can log in at www.scottsdaleinstitute.org*, click "Teleconferences" and download the Dec. 12, 2012 presentation "Meaningful Use Stage 2: Timelines / Nuances of Reporting and Penalties," Laura Kreofsky, Jason Fortin, Impact Advisors.]*

Higher but not out of reach

Some healthcare-delivery organizations may view Stage 2 of Meaningful Use as exponentially more difficult than Stage 1, but not Texas Health Resources. "It raises the bar, but it's not significantly more difficult," says Ferdinand Velasco, MD, CMIO at Texas Health, an Arlington, Texas-based health system with 25 hospitals and 5,500 affiliated physicians serving North Texas.

Texas Health Resources
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Ferdinand Velasco, MD, CMIO, Texas Health Resources

"Texas Health has been pretty well along in EHR implementation even before Stage 1 final rules. We didn't wait for HITECH to invest in IT and transform healthcare delivery," he says.

The system's Year 1 reporting period started on Oct. 1, 2010 and its facilities were among the first eligible hospitals to attest for the first 90-day period in spring 2011. Texas Health just attested for the second year of Stage 1 last month. "We're gearing up for Stage 2,"

continued

January 29
The National Quality Forum eMeasures Collaborative
- Rosemary Kennedy, VP, Health Information Technology, National Quality Forum
- Juliet Rubini, senior project manager, Health Information Technology, National Quality Forum
- Beth Franklin, RN, MS, senior director, Health Information Technology, National Quality Forum

January 30
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- John Stanley, MBA, principal, Impact Advisors

February 1
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February 5
The Challenge of Clinical Data Integration
- Michael Kamerick, specialist leader, Deloitte Consulting LLP
- Aaron Abend, director, Deloitte Consulting LLP

February 6
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says Velasco, who has served on panels for the National Quality Forum (NQF), an independent non-profit agency that reviews and comments on quality and pay-for-performance measures, and he currently chairs the HIMSS quality, cost and safety committee.

"Texas Health has always believed that clinical IT is critical to improving care for patients by supporting quality and safety, reducing medical errors and improving adherence with evidence-based clinical guidelines. So Meaningful Use, if anything, reinforced our position to improve quality and safety through effective adoption of the EHR. Meaningful Use validated our EHR strategy and sharpened our focus," says Velasco.

"We should be stretching ourselves beyond the base requirements of Meaningful Use. We shouldn't be satisfied with Meaningful Use in terms of quality and safety."

Early birds, early incentives

To date, for the first year Stage 1, Texas Health has received more than $26 million in Meaningful Use incentive payments from Medicare and Medicaid (the latter in the first year). The system is already in Year 2, whose payments are less by CMS design.

"One thing we don't do is wait until the final rule before developing our readiness plan. There's been foreshadowing of Meaningful Use objectives and measures from the HIT Policy and Standards committees and previews of them in Scottsdale Institute presentations. The typical pattern is to set the bar pretty high initially and then make it more reasonable," he says of the CMS rules.

Texas Health has been conscientious about submitting comments during the review process. "Consequently, when a federal rule comes out we don't find a lot of surprises. It's by no means perfect, but given the complexity of the process the end product is fairly reasonable. We recognize the overall trajectory of Meaningful Use Stage 2 is ultimately where the federal government wants to go," says Velasco.

Meaningful Use not the ultimate goal.

"The Meaningful Use framework isn't the be-all and end-all of EHR implementation," he says. "It's just one element—a check list. I don't see Stage 2 as that challenging. We should be stretching ourselves beyond the base requirements of Meaningful Use. We shouldn't be satisfied with Meaningful Use in terms of quality and safety. We are already looking forward to Stage 3. The HIT Policy committee has finalized their draft recommendations. No surprises there."

A key differentiator: Stage 2's much greater emphasis on clinical decision support. "That's to be applauded. Just doing CPOE alone is not effective," says Velasco, co-author of the authoritative CDS guidebook *Improving Outcomes with Clinical Decision Support: An Implementer's Guide* (Second Edition, Osheroff, Teich, Levick, et al, HIMSS 2012, www.himss.org/cdsguide), which SI supported and co-published.

A second area of emphasis for Stage 2 is interoperability, which was only a minimal requirement in Stage 1. "Ultimately, true value is how you're able to connect with the community. Again this is not something new to

us. We've been exchanging health information with local providers for a year. We also participate in another private HIE hosted by a local independent physician organization," he says, adding that in the next 60 days Texas Health will begin exchanging data in yet a third HIE, the North Texas Regional HIE.

Patient engagement is a third major focus for Stage 2. "The whole of healthcare reform is putting the patient at the center of the care-delivery process," says Velasco. This requirement means providers must give patients greater access to care and mechanisms to request prescriptions and conduct clinical messaging with their providers. Aside from those points of emphasis, the remaining Stage 2 requirements focus on raising the thresholds of Stage 1.

Stage 1 a matter of showing up

If there's an example of the complexity large healthcare systems face in addressing Meaningful Use Stage 2, ask SSM Health Care, a St. Louis-based health system with 17 hospitals in Missouri, Oklahoma, Illinois and Wisconsin. While SSM, which in 2002 was the first healthcare organization to win the Malcolm Baldrige Award, has standardized on the Epic EHR, its Wisconsin region uses its own unique version of Epic. That region includes Madison-based Dean Clinic, a 450-provider, physician-owned network 5 percent of which SSM owns, that partners with SSM St. Mary's Hospital in Madison and Janesville and SSM St. Clare Hospital in Baraboo, Wis.

"We do the Meaningful Use application for Dean Clinic and the SSM Wisconsin," says Annette Fox, RN, MSMI, director of clinical systems for the Wisconsin Integrated Information Technology & Telemedicine Systems (WIITTS), an IT partnership between SSM Wisconsin and Dean Health System, which includes the clinic and a health plan. The integrated organization has just begun addressing Stage 2 after navigating relatively easily through Stage 1.

[Members can log in at www.scottsdaleinstitute.org, click on "Conferences," scroll to Spring 2012 and download the presentation "Tranforming Healthcare at Dean: Leading the Journey to Value-based Care," Craig E. Samitt, MD, president and CEO, Dean Health System.]

"We'd been live with our Inpatient EHR since 2008 so the Hospital Stage 1 requirements like CPOE and a problem list seemed relatively easy. The big challenge in Stage 2 is electronically reporting quality measures. There are so many ways to enter the data and you have to make sure nurses and doctors do so in a consistent way," Fox says.

In terms of HIE, it's a mixed bag. Some tasks are easy, some difficult. Using the EHR vendor's HIE application has made it convenient to perform 3,000 information exchanges a month with other provider organizations in the region that use the same platform. However, Stage 2 requires exchanges with outside organizations that use different EHRs. That factor has placed Fox's group in a dilemma: whether to invest in point-to-point connections

"The big challenge in Stage 2 is electronically reporting quality measures. There are so many ways to enter the data and you have to make sure nurses and doctors do so in a consistent way."

with specific healthcare organizations or invest in joining the newly formed state-wide HIE in Wisconsin. "The technology used, costs and workflows for the clinicians are very different with these two different scenarios and we need to make the best decision for patient care and not make a decision based on which way is easiest to meet the requirement," she says.

For such large and diverse health systems it's akin to playing a game of three-dimensional chess—or perhaps several games simultaneously.

SSM faces many of the same problems throughout its four-state enterprise, with variations in the IT progress of different hospitals, checkered HIE development among the states and the perennial challenge of aligning clinicians for attestation. For such large and diverse health systems it's akin to playing a game of three-dimensional chess—or perhaps several games simultaneously.

Strengthening the Team

That's why as recently as August, anticipating Stage 2, SSM Integrated Health Technologies (IHT) appointed Jenn Sewell as project manager for EHR incentives and Meaningful Use. People like Fox were reassured to now have an executive dedicated full-time to manage the program. Tracking and managing the Meaningful Use process as it enters Stage 2 is not a part-time job. Almost all of SSM's hospitals in Missouri, Wisconsin and Oklahoma attested for Year 1 in 2011. Two southern Illinois hospitals and one mid-Missouri hospital will be implementing Epic during 2013.

Almost all of SSM's physician organizations (nearly 300 physicians not counting Dean Clinic) are on the same platform and are "in a sprint to the finish" as the reporting period ends December 31, says Sewell. One physician group in southern Illinois is on a different certified EHR and is attesting for Stage 1, Year 1 but will be transitioning to Epic in 2013 and will have to combine data from both the new and old systems to attest for Year 2. Again, because of SSM's early effort to implement a single EHR—except for an upgrade to the system—the multi-state organization was well prepared for Stage 1.

SSM HEALTH · CARE℠

Jenn Sewell, Project Manager, EHR Incentives & Meaningful Use, SSM

SSM hospitals in St. Louis can produce a summary-of-care document for patients, however, Stage 2 requires additional data elements than Stage 1 and adds the requirement that at least 10 percent of such summaries be transmitted electronically. In addition, a third requirement was added: at least one exchange must be made with a different EHR vendor or a test must be successfully completed with CMS's "Test EHR," which is uncertain because CMS has yet to select the EHR.

Fox says WIITTS does not consider the patient-engagement requirement in Stage 2 difficult because patients have been using the personal health

record incorporated into its EHR for several years. The few new functions needed to meet that requirement fall under her "Yellow" category regarding Meaningful Use Stage 2. When the requirements first came out, she categorized the requirements into three categories: Green, "items that we could meet today with little effort," such as CPOE percentage, recording demographics and vital signs; Yellow, items that would need some workflow and/or build changes, such as generating patient lists for specific conditions and the patient education requirements; and Red, items that would require significant build and/or workflow changes, such as the quality measures and public health and lab interfaces.

Another area of concern is the need to report lab data and syndromic surveillance. Again, the varying status of HIEs in different states makes it challenging for the sprawling health system to plan any single strategy. Sewell says it's difficult to identify what links are even available for accepting data. "Where do I go with lab submissions? We have a little time but if the state isn't ready that's a gap we need to fill."

Conclusion

For large integrated health systems the task of tracking, managing and achieving Meaningful Use is complex and demanding, made only more so by the simultaneous need to convert to ICD-10 coding and evolve toward accountable care. It's a job that has so many moving parts it's difficult to track them all, let alone quantify the resources expended. Still, Meaningful Use is really a clinical-IT roadmap of the larger journey toward value. What THR's Velasco says in reference to Stage 2 might be said for the entire continuum of Meaningful Use: "I feel Stage 2 is reasonable. It's not perfect, but in the overall scheme of things it's a good transition to where we need to be eventually."

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