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INSIDE EDGE

Transition to Risk: Convergence of Providers & Payers

Executive Summary

You can tell a cultural shift is occurring when the language begins to change. Old frames of reference disappear and new phrases, terms and even job titles emerge. A new lingua franca arises to better describe and shape the change we are experiencing. That is the case with healthcare. The move from volume and fee-for-service to value, accountable care and population health is generating a new lexicon that reflects the accelerated pace, complexities and uncertainties of this seismic shift.

This is the era of value in healthcare. And if value has become the watchword that transforms even the way we talk about healthcare, so much more does it transform the way we deliver healthcare and ultimately health itself. Great energy is being poured into defining value and constructing the new clinical, financial and operational frameworks to deliver on its promise.

We talk to leaders of this change, including veteran executives with "a foot in each canoe" of the old and new worlds, to better understand how they see value shaping the future. While there is no absolute clarity on what the new healthcare will look like, a convergence of the old silos of provider and payer, public and private is occurring. This convergence, fueled by the assumption of risk and accountability and accelerated by IT, is not only changing the language but the shape of the industry itself. This convergence is the focus of our 22nd Annual Spring Conference (http://www.scottsdaleinstitute.org/docs/confs/spring/2015/2015-Spring-Conf-Agenda.pdf).

Scottsdale Institute Conferences 2015

Fall Forum 2015
Oct. 29-30, 2015
Seton Healthcare Family
Austin, Texas

Winning formula still unclear

"We're seeing the move to value play out different ways with different organizations," says Mitch Morris, MD, vice chairman and global healthcare leader at Deloitte. "Back in the 1990s, everybody was going to be in a capitated model, and lots of health systems started health plans. A few like Kaiser Permanente had been doing risk from the beginning, and others like Geisinger have been in the payer business for quite some time. Also, health plans dabbled with owning providers."

Deloitte.

Mitch Morris, MD, Vice Chairman/ Global Healthcare Leader, Deloitte

Recently that trend has greatly accelerated. Health plans are saying they want to have a bigger impact in managing care and providers want to manage risk, hoping that their experience preventing readmissions and managing chronic diseases like CHF has helped prepare them for managing risk on a much larger scale.

"Health plans are worried they'll end up being third-party administrators for providers. So, there's jockeying going on," he says. For example, UnitedHealthcare, through its Optum division, is investing in large medical groups, analytics and acquiring health plans and hospitals outside the United States.

Investor-owned hospitals are enthusiastically embracing the move to risk. Academic medical centers lack scale, so they're ensuring they have lots of capital. In addition to providers buying health plans, notes Morris, "many interesting affiliations are emerging." For example, Anthem Inc. (formerly WellPoint) has entered into alliances with provider organizations like Los Angeles-based Cedars Sinai, UCLA and MemorialCare, to create an HMO product to compete with Kaiser. The contract is structured so all parties share profits and risks.

In these innovative arrangements, "Nobody owns anybody else. We're seeing a variety of alliances, affiliations, acquisitions and mergers. What the winning formula will be is still unclear."

Task force for conversion

One of the most visible volume-to-value initiatives: the January 2015 launch of the Healthcare Transformation Task Force (http://www.hcttf.org/), a coalition of health systems, payers and advocacy groups whose goal is to convert 75 percent of reimbursement to value-based payments focused on the Triple Aim of better health, better care and lower costs by 2020. Task force members reflect the convergence of providers and payers, including SI Members like Advocate Health Care, Ascension, OSF Healthcare, Partners Healthcare, SSM Health and Trinity Health. Payer members include Aetna, Blue Cross Blue Shield of Massachusetts and Blue Shield of California.

The federal government's commitment to a value-based model is driving the entire industry. Only two days before the Task Force announcement, Health and Human Services Secretary Sylvia Burwell announced a goal of having half of traditional Medicare payments tied to bundled payments and other value-based payments by 2018.

The devil's in the details, which reflect the complexities of cost.

"Much of the cost of healthcare is in the last few months of life and typically involve multiple maladies like COPD, heart function and kidney failure," says Morris. "It's so complicated. In cancer, for example, bundled payments are fine for the first-line treatment, but there can be 50 different treatments and a lot are really expensive. How do you measure value? And that's just for common cancers. If treatment is very structured around a single disease that's one thing, but the final months of life are characterized by comorbidities and that's a very complex challenge for measuring value."

Value more than just integrated health systems

As we move into value-based care, we must answer several questions:

- How do we define value?
- How do we deliver value?
- How do we make the hard decisions?

However, even following value-based-health-system models like Kaiser, does not necessarily guarantee transformative results, says Morris. "Kaiser's cost of care is lower, but only marginally lower. It's not a third or even 10 percent. So, there are other things that cry for attention like access to care, bending the cost curve and quality."

Having consumers assume more of the cost of their healthcare is already cutting utilization rates, he notes, citing the hypothetical example of a 40-year-old man who is a runner with knee pain. In the past he was likely to suggest to his sports doctor he undergo an MRI. Today, with a high deductible that could require him to pay $1,200 for the cost of the MRI scan, he's more likely to say, "Let me try some of those stretching exercises first."

Also likely to have an impact from the IT standpoint: wearable devices, home monitoring and the Internet of Things. All are changing where health and wellness are "delivered." Morris cites a prominent example: The for-profit Hospital Corporation of America is now offering a home bone-marrow transplant. "It's about saving the money."

Quest for ACOs

"We are actively pursuing ACO models around the country," says Marcus Shipley, senior VP and CIO at Livonia, Mich.-based Trinity Health, a $13.6-billion Catholic health system with 86-hospitals in 21 states. "They are enabled by clinically integrated networks managing shared savings plans and commercial programs

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Chairman
Donald C. Wegmiller

Executive Director
Shelli Williamson

Editor
Chuck Appleby

Managing Editor
Jean Appleby

Membership Services Office:
1660 Highway 100 South, Suite 306
Minneapolis, MN 55416
T. 952.545.5880
F. 952.545.6116
E. scottsdale@scottsdaleinstitute.org
W. www.scottsdaleinstitute.org

all committed to value-based reimbursements. We are also participating in the Bundled Payments for Care Improvement (BPCI) program. Delivering on the Triple Aim in the communities we serve requires an emphasis on the entire continuum of care, including skilled nursing facilities, long-term care, home care and hospice. A focus on value across the continuum will deliver better care."

TRINITY HEALTH
Livonia, Michigan


Marcus Shipley, SVP/ CIO, Trinity Health

Trinity has the most available PACE programs (http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html) in the country. PACE, which stands for Program of All-inclusive Care for the Elderly, is a Medicare and Medicaid program that helps people meet their needs in the home and community instead of going to a nursing home or other care facility, using care teams specializing in coordinated care for people over 55 who need nursing-home-level care.

As a Catholic health system, Trinity is committed to making this transition to value within its mission of serving the community, especially the poor and underserved, who are typically high utilizers of EDs and have high rates of hospital readmissions, both triggering extra costs to health systems. "This industry transition is well aligned with our mission," says Shipley.

From the top down, perhaps no health system is better poised for moving to value. Trinity President and CEO Richard Gilfillan, MD, is chairman of the afore-mentioned Healthcare Transformation Task Force, was the first director of the Center for Medicare and Medicaid Innovation (CMMI) and previously president and CEO of Geisinger Health Plan.

Capital T

Also, prior to becoming CIO at Trinity, Shipley served as an IT executive in the financial services and insurance industries. His charge is to help the health system become "people-centered across the continuum, rethinking how we deliver care in the community. This is transformation with a capital T."

That's the organizational challenge.

"The technical challenge is transitioning to the post-EHR era of health IT. There's a new genre of technology that must be employed to support people-centered care. While the EHR will remain a foundational component of the health IT infrastructure, Trinity is modernizing our platforms to address user experience, analytics and interoperability.

"On this last point, some of the vendors we deal with are closed in terms of interoperability," he says, adding that the need for interoperability standards is critical. Shipley notes that's why the Office of the National Coordinator for Health Information Technology (ONC) has published a "A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure" and other resources on interoperability, available at http://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf. He is working closely with the American Hospital Association to influence the ONC to create interoperability standards for the industry.

Executive juggler

Kevin Sears, senior VP of payer strategy and product development at Trinity Health, oversees all payer relationships and contracts, from traditional fee-for-service to more creative gain-sharing, symmetrical risk, capitated risk, bundled payment—or partnerships with payers to jointly build insurance units for Medicare Advantage, public exchanges and directly with employers.

"It is complicated, but it's also a lot of fun," he says, because there's so much innovation occurring in healthcare.

> *"It is complicated, but it's also a lot of fun."*

"Our goal is 75 percent of revenue from value-based payments by 2020. Two years ago when we started the journey, we had none. Today 15 percent is value-based. We've got a lot of work yet to do, and it needs to be very thoughtfully developed and deployed," he says.

It's critical to ensure Trinity's pace of clinical transformation is aligned with the pace of transition to new payment models. "It's very important to keep those two aligned or you can create an adverse financial outcome," he says.

Lead dog

The change leader is clinical transformation, changing care delivery from an individualistic encounter view to a holistic, people-centered view focused on doing better care at lower costs across the entire continuum of services. "We're no longer just concerned with what's happening within the walls of the hospital or doctor's office. That's really the transformation in the lead. Our responsibility is that as we evolve the clinical models we align our payment models with the clinical model," says Sears.

Moving from an encounter view requires a simultaneous move toward per-capita payments, he notes. "If you think about total cost of healthcare, you look at per member per month and multiple components come into play:

- Unit cost of service,
- Intensity of service, and
- Utilization rate.

"Fee-for-service only focuses on unit cost and encounter level. If you move to a bundled payment you also contemplate service mix and intensity. Do I need a CT scan, a plain-film x-ray or an MRI? Do I need to send this person to a skilled nursing facility or home health if I get the same clinical result either way? When you move to capitation, you do everything you did for fee-for-service but also introduce utilization rates. Should I be doing surgery at all? You focus more broadly. Capitation really focuses the provider on better unit cost, making the right decision on the site of service and utilization," Sears says.

Turning such a large ship as Trinity to this new way of thinking requires a new executive framework.

Desperately seeking payer experience

Trinity continues to invest heavily in resources to help its leaders in various regional health ministries (markets) to understand what stage their market is in transition to value, including analytical tools to develop the right strategic framework. Subject-matter experts—really, internal consultants—in the central office also assist them. Trinity also has developed clear guidelines around approvals and an authority matrix to ensure agreements the health system is working on are in line with the markets and payer mix.

"Executives capable of running these regions well are scarce resources," he says. "We allow quite a bit of lead time to find these people. We hire a number of people out of the insurance industry—Aetna, Cigna and United, for example. There's the convergence. I also have an actuarial department. Four years ago Trinity didn't have an actuarial department. However, because of capitated rates and arrangements with payers or product pricing we need very strong, experienced actuaries today. That's an example of a new skill set."

Although Sears stresses insurance will never become its primary business, Trinity owns several insurance companies in various markets. There's no single model. In markets in which it has strong relationships with traditional insurers, there's no reason to take that role. "Other markets we may need our own insurance arm. The general rule is our sweet spot: an assurance from the payer taking on the financial, actuarial, clinical risk from the membership, we are able to generate a modest margin."

The matrix

In certain markets, Trinity assumes many payer functions:

- Care management
- Disease management
- Care coordination, and, in many instances,
- Paying claims to other providers.

In these cases, traditional insurance firms will then assume:

- Eligibility
- Enrollment
- Customer service, and
- Licensing and compliance

"We have a matrix with all of the functions associated with population health. We go through them line by line and decide who's responsible for each," he says.

Trinity still has many traditional insurance arrangements based on fee-for-service contracts. These negotiations are very traditional and even adversarial in negotiation. Trinity has developed a "Partnership Framework" with key criteria:

- Partnership
- Collaboration
- Transparency
- Aligned interest

"If a payer is willing to meet those criteria, then we transition to more of a relationship. If a payer doesn't want to transition, that's ok. There will always be some business coming to us that is fee-for-service," says Sears.

'No data, no deal'

Data and information are critical to entering into any arrangement.

"Whenever we're contemplating the new relationships or methodology, it's essential we have the right kind of data and it be accurate," he says. "In order for us to be able to contract risk relationships we need transparency from the payer so we can standardize and analyze claims data—and marry that data to clinical and financial data. Our mantra is 'No data, no deal.' We simply cannot get into one of these risk arrangements without having defined the

data, the data format and the frequency with which it comes in. Without that guarantee it's impossible to structure one of these relationships. With that, both parties will come out of this favorably."

"We simply cannot get into one of these risk arrangements without having defined the data, the data format and the frequency with which it comes in."

Trinity typically demands at least 24 months of claims history of the population it will manage in order to formulate per-member-per-month payment or percent of premiums. "We use analytics that insurers have been comfortable with a long time," he says.

The transition to risk has necessitated Trinity Health to build additional data warehouses and data marts, while also acquiring software applications to stratify risk, target risk-adjusted populations, monitor performance and be able to modify care across the continuum.

High stakes

Actuarial analysis resides with business owners. The underlying data infrastructure, including data warehouses, data marts and software-apps implementation fall under the aegis of IT. "It's an opportunity to partner. It's not something to be taken lightly as if it were a special project. Getting these arrangements structured correctly is the difference between being a vibrant, healthy organization and one that ends up in bankruptcy," says Sears.

That said, the business side gets involved in selection of certain IT vendors. For example, Sears' business team partnered with IT in a year-long vendor-selection process for acquisition of a key analytics platform from Verisk as a tool to stratify risk and monitor performance.

And what about the EHR? "I think the EHR will continue to serve as a foundational element. It's necessary, just not sufficient. We also need a good registry and claims-based analytics. They all need to come together in a complementary way."

Data sciences in Ascension

"We've been evaluating, implementing and investing in a number of innovations in data sciences and analytics," says Mark Barner, president and CEO of Ascension Information Services and senior VP and CIO of St. Louis-based Ascension, the largest not-for-profit health system in the country—and the largest Catholic one—with 131 hospitals and more than 30 senior care facilities in 23 states and the District of Columbia, $20.2 billion in annualized revenue and more than 150,000 associates and 35,000 affiliated providers serving in 1,900 sites of care.

"Data and analytics are critical to delivering higher quality, reasonable cost care wherever we see someone, whether that's at the bedside, clinic, via telemedicine, or at home. We're aware of this every day because healthcare's new normal is all about give me that data, get it to me quickly, and get it to me with high quality and high reliability," he says.

Microcosm of value

As large as it is, Ascension is a microcosm of the industry shift from fee-for-service to value-based care across the continuum because it encompasses every possible marketplace. And like every provider organization it faces a major obstacle to getting that data quickly and reliably: lack of interoperability.

Nearly a third of Ascension's hospitals have reached HIMSS Analytics Stage 6 (out of 7) in the EMR Adoption Model (http://staging.himssanalytics.org/emram/emram.aspx), but, "We still have work to do," says Barner. "We have 14,000 interfaces with all that data moving around. Ascension is searching for cost-effective interoperability platforms. We don't have the luxury of long implementation cycles anymore—time is of the essence. It's got to be quicker, better, cheaper, faster and more secured."

Mark Barner, SVP/ CIO Ascension Health

Ascension's clinical data resides in various locations, with multiple meanings and formats, and disparate EHR platforms from several vendors. Add to that the proliferation of digital and mobile devices and it's clear this is not a case where 'the technology is the easy part.' "You bet that's a challenge toward being value-based," he says. Possible solutions include special middleware that acts as an interoperability platform and that eliminates the need for interfaces.

No more 'avoid being all in'

Cleaning up and standardizing the clinical data is a top priority, but is further complicated by its high velocity. "Clinicians want to know more, faster," says Barner. The language of IT management is changing along with this new dynamic of value-based care. Barner has discarded old IT chestnuts like "Avoid being all in," for new phrases like "Failing Fast. Learning Fast," which means you can either fail fast

and drop a strategy, or learn fast and add more data. Other taglines like "proof of concept," "field testing" and "piloting," signal a shift to a new nimbleness.

Speed to market is overriding. What in the past required years of work, such as an EHR implementation, must now be done ideally in weeks; this is especially true with data projects. "We're not in an environment in which we can spend four years on an Enterprise Resource Planning go-live across a set of hospitals anymore," he says.

A big driver of the need for speed is the world's consumer focus and associated disruptive technologies. Smartphones weren't around in the early EHR era, and computers on wheels (COWs) were once considered a novelty. Still, "We continue to implement EHR functionality, partly because it's the repository of so much data. We'll never be done with that EHR journey. We need to get into that data in the monolithic EHR and pull out the value," Barner says.

"We understand that we must become even more consumer-focused and provide services in a way that is aligned with that philosophy. We are significantly investing in mobile solutions, social media, provider and individual portal technologies to engage the people we serve, care providers and communities in a manner that provides the interaction and information sharing they need and the way they prefer. It isn't a new world, it's an evolving world," he says.

"It isn't a new world, it's an evolving world."

Data liquidity

Health systems like Ascension increasingly believe data must be managed as a strategic asset, whether that data comes from the bedside, a physician's office, telemedicine or the community. With multiple EHRs and 3,000+ software apps, the vision is to extract, aggregate, normalize and use that data for value. And that requires people with the right skill sets and expertise to use technology to effectively convert existing disparate data to usefulness throughout the integrated health system. Barner refers to this as "data liquidity:" to convert existing, disparate healthcare data to a commodity to be effectively used with the liquidity needed to ensure the right information, in the right context for care management—this goes back to Barner's message on the "richness" of the data.

Data liquidity means all appropriate users—clinicians, social workers, patients, insurers--can access secured information quickly and easily on any device, ranging from smartphones to tablets to PCs.

Chief Data Officer is the most visible of Ascension's new roles that reflect the move to value. Gerry Lewis, VP of IT strategy and business development, Ascension Information Services, holds this executive role, whose job is to develop a framework that optimizes new, existing and legacy data assets and creates a centralized way to connect data and information assets to strategic business needs. Besides IT strategy enterprise architecture, mobile apps, social media and innovative data strategies, Lewis now oversees development of a framework to optimize and manage data from a system view. This is a daunting but critical task in the sprawling organization. (visit July 29, 2014 SI Teleconference by Gerry Lewis on "IT Value Measurement at Ascension at http://www.scottsdaleinstitute.org/teleconferences/2014.asp)

Gerry Lewis, Associate VP, Strategic Planning, Ascension IS

He's not alone. Ascension also has a stack of new titles with the prefix "data": architects, analysts and stewards. "These people are coveted," says Barner. "They can really talk the business side of data and also have the ability to interpret that side for IT." More technical new titles include ETL developers (key data-based functions of extract, transform, load), dimensional data modelers and integration analysts.

Anywhere but healthcare

Paul Posey, president of Ascension Risk Services, an Ascension subsidiary, is emblematic of the new executive type sought by health systems to help navigate the move from volume to value. Trained as an attorney, Posey arrived a year ago with experience in the insurance industry and as an entrepreneur—but none in healthcare.

"When I was first contacted about this position and the new role of Ascension Risk Services, I said, 'I've never operated in healthcare,'" he recalls. "At the interview they told me, 'We have 150,000 associates and need very innovative executives serving business leaders with new ideas. We have a corps of business leaders of different backgrounds who bring operational expertise and entrepreneurship to the table and we want these individuals to cross-pollinate."

Ascension Risk Services is the newest of Ascension's subsidiary organizations that include information services, supply chain, complex medical imaging and venture capital. Besides traditional property and casualty risk, its scope includes cyber risk, insurance and remediating privacy and security.

Because assuming risk demands quick access to clean, sense-making data that can be applied to myriad market-driven payment arrangements, business and IT must work closer together than ever before. "Mark [Barner] and I work together as part of many teams," says Posey.

Ancient mission of value

Still, despite the tremendous change occurring, moving to a value-based model of care is like back to the future. "Ascension's starting premise is the religious orders whose mission is to heal. We're very shrewd business people, but if our mission is to heal, then transitioning to population health management is not philosophically different than that original mission, which is to efficiently tend to the needs of the whole person.

Paul Posey, President, Ascension Risk Services

"Technology will help us do that like never before. Healing the whole person requires knowing a lot about them—not just age, weight and blood pressure, but in the future could include socio-economic information, how far they live from medical providers and their social support network. So, part of the job is to use data to understand and treat the entire person. In diabetic care alone, access to reliable transportation for medical care can substantially influence health outcomes. The question is, how can we use technology and data to serve people better? Change will be difficult and there will be winners and losers, but if we focus on our mission, we can keep our eye on the prize."

Flexibility is also key. While Ascension uses common and accepted standards for constructing payer arrangements, those are always matched to individual markets, which can vary from a large, sophisticated market with substantial market share to a standalone hospital in a smaller market. Mostly through acquisitions, Ascension owns six health plans ranging from Medicare Advantage and Medicaid to commercial insurance. Overall, Ascension manages about 2 million lives covered under some type of value-based arrangement.

"We are continually developing and refining a playbook to help our regional ministry executives navigate the vagaries of local markets and create new value arrangements," he says. Ascension also deploys councils of diverse health teams—traditional hospital executives, CMOs, care-management executives and other leaders—to exchange best practices and help set policy for a diverse and fluid landscape.

Holy alliance

"Our strategy is customized and market-driven. We're always trying to strike a balance, and trust local leadership to make the right call," says Posey. "We invest, support and introduce best practices, but if it worked in Nashville, it's not necessarily going to work in Austin. It's very much a collaborative effort with local leadership and the community. It's not top-down or authoritarian. We're continually looking for alliances."

Chicago is a case in point. In February, Alexian Brothers Health System, part of Ascension, and Adventist Midwest Health, part of Florida-based Adventist Health System, announced creation of a joint operating company (JOA) that combines nine suburban Chicago hospitals serving a population of nearly 4 million people. Going the affiliation route allows the two systems to retain their religious identities while creating a network of more than 3,000 physicians to deliver coordinated, comprehensive care. "We knew that a true merger wasn't viable, but a JOA allows us to have a combined board and share financial results," says Posey.

Given that physicians are finding it increasingly difficult to survive in standalone practices, Ascension's strategy is to, well, first do no harm. "We can't do anything to make things worse for physicians. We have to support them wherever we can, whether it's getting patients on their panels, helping schedule those patients or providing those docs core services. When they win, we win."

Conclusion: Need for trust drives convergence

Change in healthcare is ultimately being driven by the collapse of the economic foundations of fee-for-service whose contradictions have been widely criticized for decades. However, we are also experiencing a cultural collapse as the ensuing uncertainty has resulted in a loss of trust. It's an issue often missing in the discussion of what new models of care and financing will emerge under value-based care.

"Nobody trusts health plans or health systems to make decisions for you," says Deloitte's Morris. "We used to trust doctors, but that has changed. Providers have the best shot at creating a new foundation of trust on value-based care. That's what is driving a lot of this convergence."

Trust. Perhaps that's a word that we need to reintroduce to the lexicon of value. In that sense, convergence may be more about a new way of looking at the provider-patient relationship. This is the most exciting time in healthcare.

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