Modern Healthcare

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HEROES

Stories from the front lines show courage in the face of personal adversity

Page 20

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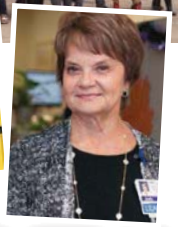

HEROES

20 Cover story

This year's healthcare heroes

By Matthew Weinstock

From natural disasters across the country to another string of horrific mass shootings, when disaster struck, healthcare professionals stepped up. They say they were just doing their jobs, but time and again their actions went above and beyond.

Photos on cover and p. 20: AP and Getty Images

Features

14 2017 in the rearview mirror

We take a look back at key moments of the past year, starting with the inauguration of a new president and ending with a flurry of activity in corporate boardrooms and the halls of Congress. View our timeline on what happened in between.

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Awards and Recognition

Top 25 Minority Executives in Healthcare

The deadline is quickly approaching to nominate innovative and transformative minority executives throughout the healthcare industry. Nominations are due Jan. 8. **/Minority**

Resources

Making sense of MACRA

Looking for help in meeting the complex requirements and deadlines under MACRA. Our site offers resources, timelines and an archive of our coverage. **/MasteringMACRA**

Modern Healthcare

contents

This is a combined issue for Dec. 18 and 25. The next issue will be published Jan. 1.

The staff of Modern Healthcare wishes our readers happy holidays and all the best in the new year.

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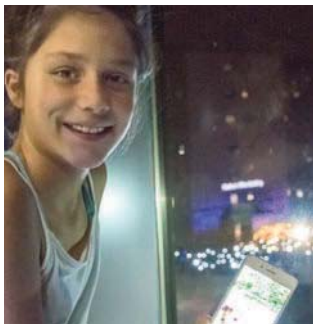
People

Opinions/Ideas

"We want our advocacy to make a difference in the lives of our members, their physicians and their patients."

Data



Diversions

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late news

CHS' $891 million securities fraud lawsuit gets a second life

A federal appeals court last week revived an $891 million securities fraud lawsuit alleging Community Health Systems intentionally inflated its financial health.

A three-judge panel for the 6th U.S. Circuit Court of Appeals unanimously ruled that shareholders plausibly alleged that CHS' shares plummeted in value due to revelations that the hospital chain allegedly billed Medicare for unnecessary patient stays.

The misrepresentations convinced investors that CHS' revenue was sustainable "when in fact they were not," U.S. Circuit Judge Raymond Kethledge wrote for the panel.

The shareholders initially sued CHS, CEO Wayne Smith and former Chief Financial Officer Larry Cash in 2011, claiming the revelations ultimately lost them $891 million. They claim that Smith and Cash avoided the shareholders' fate by selling their own CHS shares before their value dropped, with each netting over $7 million.

But a federal trial court dismissed the earlier suit, ruling that the shareholders had not adequately shown that misleading statements from CHS officials sparked the stock price fall.

Tomi Galin, a CHS spokeswoman, wrote in an email that the plaintiffs have presented no evidence to support their claims. **—Tara Bannow**

Repeal of net neutrality worries advocates of telemedicine

The Federal Communications Commission's decision to end so-called net neutrality has some healthcare experts worried about the effect on telemedicine.

In a 3-2 vote last week, the FCC spiked an Obama-era regulation that prohibits internet service providers from blocking or slowing web content. The move lets ISPs segment traffic into different "lanes," essentially creating faster and slower movement across the web.

Those differing speeds could hurt telemedicine since it requires a "pretty robust connection," said Mei Kwong, interim executive director and policy adviser for the Center for Connected Health Policy. "The last thing you want is for the interaction to suddenly freeze or the audio to go out or for the picture to be pixelated."

Though the FCC could make exceptions for healthcare so it's not subject to the same rules, Kwong and others said, that might still leave patients to fend for themselves.

"What do you do then for the individual who's at home and trying to get services at home?" Kwong asked.

The vote, led by FCC Chairman Ajit Pai, came a few months after the agency's comment period closed. Of the 21.7 million comments submitted, the Pew Research Center recently found that only 6% were unique, with some of the other comments submitted hundreds of thousands of times.

Eighteen state attorneys general called for the vote to be postponed over concerns that 2 million Americans' identities were falsely used to comment on the net neutrality proposal.

The FCC also voted to adopt a proposed rulemaking to give the Rural Health Care Program more money for helping rural providers modernize their communications services. "It's becoming harder for rural patients to receive healthcare," Pai said. "That's what makes the combination of the internet and rural medicine so critical." **—Rachel Z. Arndt**

Briefs

■ **A judge blocked a proposed merger between Sanford Health and Mid Dakota Clinic** until a Federal Trade Commission hearing next month. North Dakota Attorney General Wayne Stenehjem and the Federal Trade Commission allege the deal would violate antitrust law by significantly lessening healthcare competition in the Bismarck-Mandan area. Sanford and Mid Dakota called the decision disappointing, and said the government's case "rests on theories that are at odds with reality here in North Dakota."

■ **Dr. J. Mario Molina resigned from the board of the health insurer his father founded,** Molina Healthcare. The insurer said its former CEO, who led the company from 1996 until May 2017, will pursue other opportunities. Molina is in the process of buying 17 primary-care clinics from the insurer. The politically outspoken Molina and his brother John, then chief financial officer, were ousted from Molina Healthcare in May 2017 due to what the insurer called "disappointing financial performance."

■ **HHS' Office of Inspector General said in a Dec. 14 report that implementation of MACRA still faces challenges because of doctors' confusion about the program and it remains at risk for fraud.** In the 30-page report, the OIG said that although clinicians are largely aware of the Quality Payment Program, many are still uncertain about the technical details, including how to report and submit data. The watchdog agency said without sufficient technical assistance from the CMS, clinicians "may struggle to succeed under the Quality Payment Program or choose not to participate." The agency also said the CMS has yet to develop and implement a "comprehensive" integrity plan that would protect the program from fraud or improper payments. In response to the report, the CMS said it's in the "early stages of developing an oversight plan for QPP data."

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Modern Healthcare

EDITORS

Aurora Aguilar Editor
312-649-5218 aaguilar@modernhealthcare.com

Matthew Weinstock Managing Editor
312-397-7585 mweinstock@modernhealthcare.com

Paul Barr Features Editor
312-649-5418 pbarr@modernhealthcare.com

Erica Teichert News Editor
212-210-0209 eteichert@modernhealthcare.com

David May Assistant Managing Editor
312-649-5451 dmay@modernhealthcare.com

Patricia Fanelli Art Director
312-649-5318 pfanelli@modernhealthcare.com

Keith Horist Production Manager
312-649-5467 khorist@modernhealthcare.com

Merrill Goozner Editor Emeritus
mgoozner@modernhealthcare.com

DIGITAL

Blair Chavis Web Producer
312-649-5225 bchavis@modernhealthcare.com

Emily Olsen Web Producer
312-649-5482 eolsen@modernhealthcare.com

Fan Fei Digital Graphics Producer
312-280-3155 ffei@modernhealthcare.com

SENIOR REPORTER

Harris Meyer Chicago
312-649-5343 hmeyer@modernhealthcare.com

REPORTERS

Rachel Z. Arndt Chicago
312-649-5314 rarndt@modernhealthcare.com

Tara Bannow Chicago
312-649-5362 tbannow@modernhealthcare.com

Maria Castellucci Chicago
312-397-5502 mcastellucci@modernhealthcare.com

Virgil Dickson Washington Bureau Chief
202-434-4552 vdickson@modernhealthcare.com

Steven Ross Johnson Chicago
312-649-5230 sjohnson@modernhealthcare.com

Alex Kacik Chicago
312-280-3149 akacik@modernhealthcare.com

Shelby Livingston Nashville
843-412-6857 slivingston@modernhealthcare.com

Susannah Luthi Washington
202-434-8462 sluthi@modernhealthcare.com

RESEARCH

Megan Caruso Research Associate
312-649-5471 mcaruso@modernhealthcare.com

COPY DESK

Julie A. Johnson Copy Desk Chief
312-649-5236 jajohnson@modernhealthcare.com

EDITORIAL SUPPORT

Valerie Lapointe News Intern
312-280-3173 vlapointe@modernhealthcare.com

CUSTOMER SERVICE
877-812-1581 customerservice@modernhealthcare.com

Modern Healthcare editorial offices at: 150 N. Michigan Ave., Chicago, Ill. 60601-7620; 685 Third Ave., New York, N.Y. 10017-4036; 104 East Park Drive, Building 300, Brentwood, Tenn. 37027; 1200 G St. NW, Suite 859, Washington, D.C. 20005; 1975 W. El Camino Real, Ste. 304, Mountain View, Calif. 94040Member of Business Publications Audit of Circulation.

the week ahead

Healthcare issues loom large as Congress tackles spending bills, tax reform

Buckle up, it's going to be a bumpy ride.

Congress is heading into its final week of action before the end of the year. Whether the entire government shuts down remains to be seen. The current continuing resolution—a stopgap that Congress uses to sustain government funding when lawmakers can't pass a more comprehensive budget—ends Dec. 22. Members of both chambers have been scrambling to assemble a short-term spending plan to keep the lights on until Jan. 19.

As usual, Defense Department appropriations are a major sticking point, but this year healthcare issues are front and center as well.

Steep divisions remain, not just along party lines but between the House and Senate. House conservatives support the defense bill and don't want extra spending provisions beyond the reauthorization of the Children's Health Insurance Program and federally qualified health centers. But the plan they've laid out to pay for CHIP and health centers is meeting stiff opposition from Democrats.

House Republicans want to fund the five-year CHIP reauthorization with money from the Affordable Care Act Prevention and Public Health Fund and higher Medicare Advantage premiums for wealthy people. This bitter fight over the so-called pay-fors has kept CHIP in limbo for months. Funding for Medicare programs that are crucial for rural hospitals and money to help battle the opioid crisis also hang in the balance. And, at deadline, it still wasn't clear what was going to happen with ACA cost-sharing reduction payments for insurers.

Rep. Frank Pallone (D-N.J.), the top Democrat on the Energy and Commerce Committee, which oversees health policy, said he is hopeful that the Senate can force the House's hand and shake loose some money for healthcare programs.

"Can the Senate send back a clean CR and lose some Republican votes and gain some Democrats? We won't know until we go through motions," said Rep. Tom Cole (R-Okla.), chairman of the House's health appropriations subcommittee.

As if that weren't enough, GOP leaders are eager to pass their massive tax overhaul bill quickly. Key healthcare issues—besides the likely repeal of the ACA's individual mandate—are in play, including:

- **Ending the tax exemption** for municipal private activity bonds, which are used by hospitals to finance capital projects.
- **Ending tax breaks** for higher education, including the tax exemption for tuition waivers for graduate medical students.
- **Ending the corporate tax deduction** for debt, used by companies like Tenet Healthcare Corp. and Community Health Systms.
- **Imposing a new excise tax** on compensation to not-for-profit executives exceeding $1 million.
- **Imposing a new tax** on endowments of universities and academic medical centers. **—Matthew Weinstock with Susannah Luthi and Harris Meyer**

regional news

MIDWEST

Health information accessed in hack at Henry Ford system

More than 18,000 files with personal health information on Henry Ford Health System patients were viewed or stolen in early October by an unknown person or entity who hacked the Detroit-based system's electronic health records.

Henry Ford officials said it is not clear whether the 18,470 patient files have been used for inappropriate purposes.

Henry Ford first learned of the incident on Oct. 3 after someone gained access to or stole the email credentials of a group of employees. The employee credentials are name- and password-protected by encryption. The email accounts had patient health information.

In 2010, Henry Ford experienced a patient data breach when a laptop containing patient data was stolen from an unlocked office. Healthcare organizations are required to notify patients within 60 days of a data breach.

Henry Ford said patient information viewed or taken may have included their name, date of birth, medical record number, provider's name, date of service, department's name, location, medical condition and health insurer. Social Security numbers or credit card information were not compromised, system officials said.—**Jay Greene, Crain's Detroit Business**

WEST

Pharma companies sue to block Calif. drug-price law

Pharmaceutical companies have sued to block a new California law that would require them to give regulators advance notice before big price increases.

The Pharmaceutical Research and Manufacturers of America said in its lawsuit that California's law illegally tries to dictate national health policy. Because the law is tied to a national measure of drug prices, PhRMA argues that California's advance notification requirement could restrict drugmakers' ability to raise prices in other states.

The group also argued the law is unconstitutionally vague and violates the First Amendment by forcing drug companies to justify price increases.

The law, set to take effect Jan. 1, passed despite fierce objections from PhRMA and California's thriving medical research industry. It requires 60 days' notice to raise national wholesale prices above a certain threshold.

NORTHEAST

Fenway Health CEO quits in wake of sexual harassment claims against doctor

The CEO of Boston-based Fenway Community Health Center, also known as Fenway Health, has resigned after the Boston Globe reported on years of sexual harassment allegations against a doctor at the center.

The Globe reports that CEO Dr. Stephen L. Boswell left his position under pressure from Fenway's board of directors, employees and donors. Boswell was CEO for 20 years at Fenway, which specializes in care for LGBT patients.

The Globe investigation uncovered that Dr. Harvey J. Makadon remained at Fenway years after the first serious harassment complaint arose in 2013.

Fenway had twice paid a law firm to look into charges against Makadon. The Globe investigation found Boswell had ignored the firm's advice in 2015 to fire Makadon, and Boswell failed to report the firm's findings to the board.

The board also did not learn of a $75,000 settlement paid to a former male employee over allegations Makadon harassed and bullied him. Makadon had allegedly sexually harassed at least three male co-workers at Fenway. The Globe also found he "yelled at and belittled" male and female staff members.

According to center employees, Makadon resigned in March, shortly after the board learned of the allegations.

Fenway Health is affiliated with Beth Israel Deaconess Medical Center.

SOUTH

Gwinnett invests $2.9 million to address psych boarding

Gwinnett Medical Center in Lawrenceville, Ga., last week opened a new 5,000-square-foot specialized behavioral health unit that can hold up to eight patients at a time.

Michael Boblitz, vice president for planning and business development, said the number of mentally ill patients coming into its two hospitals' emergency departments has risen 20% annually over the past several years, despite only having a 1% overall rise in ED visits.

So Gwinnett's leadership team invested nearly $3 million to create the new unit where patients can be monitored and cared for by behavioral health professionals while they wait to be transferred to another facility.

Boblitz said a full-time staff of contracted behavioral healthcare professionals will triage patients within the unit while the system's ED nurses and other clinicians will be assigned to provide for their medical care needs.

Funding woes stymie progress on Cures Act mental health programs

By Steven Ross Johnson

The much ballyhooed 21st Century Cures Act was supposed to be a springboard for fixing the nation's ailing behavioral health system. But policy officials last week acknowledged that funding fights have virtually halted any progress that the law was intended to make.

The Cures Act, signed into law one year ago this month, included provisions to create a new HHS assistant secretary position to oversee mental health and substance abuse disorder treatment services and ensure compliance with mental health parity rules; it also mandated funding for mental health block grants.

"A law is not worth the paper it's written on if it's not implemented properly," Senate Health, Education, Labor and Pensions Committee Chairman Lamar Alexander (R-Tenn.) said last week during a hearing on the law. "I intend to ensure the 21st Century Cures Act is fully and properly implemented."

But Dr. Elinore McCance-Katz, HHS' first assistant secretary for mental health and substance use, said the department has been hard at work identifying policy changes.

In fact, a day after the hearing, a coordinating committee—also mandated by the Cures Act—issued its first report to Congress assessing policy gaps. The report found shortages of psychiatrists within 96% of U.S. counties. Overall, their number has decreased by 10% from 2003 to 2013.

One of the goals of the Interdepartmental Serious Mental Illness Coordinating Committee was to develop ways to improve the system to provide a continuum of care for those with a serious mental illness or children who experience serious emotional disturbances.

AP IMAGES

Dr. Elinore McCance-Katz, HHS' first assistant secretary for mental health and substance use, said the department has been hard at work identifying policy changes.

THE TAKEAWAY

One year after its passage, several of the 21st Century Cures Act's provisions aimed to improve access to mental healthcare remain unfunded.

Among the panel's recommendations are making mental health screening and early intervention a national standard for children, eliminating the use of solitary confinement and restraints, and training all first responders on the best ways to work with a person they encounter who is experiencing serious mental illness.

Overall, approximately 35% of adults with serious mental illness in 2016 did not receive treatment, according to the report. The committee called for greater access to treatment approaches like cognitive behavioral and dialectical behavior therapies among patients within public mental healthcare facilities. The report also recommended providing additional resources toward addressing substance use disorders among those with serious mental illness, where only 12% of the estimated 2 million living with both conditions received treatment for both in 2016.

John Snook, executive director for the Treatment Advocacy Center and a member of the committee, said work is ongoing to turn the report's findings into actionable policy decisions. "That will be the measure of success—whether or not these just end up as smart ideas on a shelf or if they actually change the way we provide the level of care throughout the country," he said.

Beyond a fragmented healthcare system, there will be challenges in overcoming many of the political obstacles that have stalled movement on many aspects of the Cures Act.

The law called for Congress to allocate $1 billion over the next two years to support state healthcare efforts. About half of the funding has been distributed. But lawmakers in several of the hardest-hit areas of the country claim the money is unfairly sent to more populous states.

When asked at the hearing wheth-

> **"Congress has an awful habit of talking a really good game on mental health and addiction but then never being willing to actually meet our rhetoric with resources."**
>
> **Sen. Chris Murphy (D-Conn.)**

er the Substance Abuse and Mental Health Services Administration would consider changing how the money is distributed, McCance-Katz said that would require states to re-apply and therefore was not something the agency was looking to pursue.

Sen. Sheldon Whitehouse, a Democrat from Rhode Island, which had the fifth-highest overdose death rate in the nation in 2015, rebuked the statement.

"So for the sake of the process convenience for all, the high-intensity states are going to pay the price?" Whitehouse asked.

Congress has delayed authorizing much of the 21st Century Cures Act funds as lawmakers work on passing a new budget. Some of those measures include $30 million for suicide prevention, $5 million to address maternal depression, and $12 million to expand crisis response.

"Congress has an awful habit of talking a really good game on mental health and addiction but then never being willing to actually meet our rhetoric with resources," Sen. Chris Murphy (D-Conn.) said during the hearing. Murphy was one of the chief architects of the Senate version of the law's mental health provisions.

As GOP lawmakers look to cut domestic spending, behavioral health and substance abuse services will likely be on the chopping block.

President Donald Trump has already slashed some funding. His fiscal 2018 budget proposal calls for Community Mental Health Block Grant funding to be cut from $532 million in 2017 to $416 million next year. ●

New accreditation approach could curtail growth of micro-hospitals

By Virgil Dickson

One of the industry's fastest-emerging trends—micro-hospitals—could take a hit thanks to new CMS guidance that has hospital accreditors tweaking their policies regarding what counts as a hospital.

Micro-hospitals are small-scale, inpatient facilities with eight to 15 short-stay beds. They perform many of the same acute-care and emergency services done at larger hospitals, but are cheaper to operate. Micro-hospitals have cropped up in 19 states, mostly in underserved urban locations or areas that are farther away from large hospitals, according to Leavitt Partners.

The Joint Commission, the Healthcare Facilities Accreditation Program and DNV have announced they won't conduct surveys at facilities without at least two active inpatients. The CMS requires hospitals to be accredited in order to receive Medicare payments.

The organizations announced they are making the policy change in response to an under-the-radar guidance the CMS issued in September.

In that document to surveying organizations, the agency outlined an updated viewpoint on Medicare's statutory definition of "hospital" and what's needed for a facility to meet the definition of "inpatient facility." The guidance states that a hospital must have two inpatients at the time of survey so surveyors can directly observe the actual care to inpatient beneficiaries.

The Social Security Act requires hospitals billing Medicare to be "primarily engaged" in providing services to inpatients.

Prior to the CMS' declaration in the fall, there was no guidance with respect to what it took to be considered "primarily engaged" or to count as an inpatient provider.

Setting the record straight

The CMS clarified what it means to be a hospital:

"Hospitals must have **at least two inpatients** at the time of the survey in order for surveyors to conduct the survey. However, just because a facility has two inpatients at the time of a survey does not necessarily mean that the facility is **primarily engaged** in inpatient care and satisfies all of the statutory requirements to be considered a hospital for Medicare purposes. Having two patients at the time of a survey is **merely a starting point** in the overall survey and certification process."

If smaller hospitals are not deemed to be primarily engaged in inpatient care, they may be prohibited from providing medical services or be paid at a lower rate for free-standing facilities, according to Brian Jent, an attorney at Hall, Render, Killian, Heath & Lyman.

He is pleased that there is finally guidance on the meaning of "primarily engaged," but concerned that some may not be able to meet the clarified standard, largely due to the shift to outpatient services. "As hospitals decrease the number of inpatient beds, maintaining an average daily census of two may become difficult in some areas," Jent said.

David Muhlestein, chief research officer at Leavitt Partners, agreed that these facilities' focus on outpatient care could have consequences. "This could lead to some of these facilities closing," Muhlestein said.

THE TAKEAWAY

Surveyors that assess hospitals for compliance with federal and state laws are implementing a new policy that could lead to the closure of some so-called micro-hospitals.

Officials from Emerus Holdings, the nation's first and largest operator of micro-hospitals, had mixed reactions to the new surveyor guidance. While they were happy that the CMS clarified the meaning of "primarily engaged in inpatient care," calling the guidance much needed and long awaited, they had concerns about the two-patient requirement. It's unclear if the same two patients have to be observed during the survey window.

"We believe the appropriate measure should be the number of inpatient admissions during the survey, rather than just at the moment a surveyor appears on site, as surveys typically takes two to three days," said Richard Bonnin, an Emerus spokesman. Emerus, which has more than 27 facilities nationwide, partners with local systems to build micro-hospitals. The company in October inked a joint venture with Allegheny Health Network, part of Highmark Health, to open at least four facilities in Western Pennsylvania.

Other concerns are that the guidance was released without a public comment period, is effective immediately, and has a 12-month look-back period for compliance when there was not any clear guidance on expectations. That could affect the validity of surveys already performed.

The better approach would be to have 12 months to comply with the new guidance, then apply a 12-month look back, Bonnin said. ●

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Courts move into slow-moving world of organ allocation for transplants

By Susannah Luthi

The week before Thanksgiving, 21-year-old Miriam Holman breathed through an artificial machine in the Columbia University Medical Center intensive-care unit. Her disease—a rare form of pulmonary hypertension—is incurable and she is in danger of dying soon without a lung transplant.

But she lives in New York, or, in organ allocation parlance, Region 9, which has fewer locally procured organs than most other regions, according to data from the United Network for Organ Sharing.

UNOS, the private, not-for-profit organization in charge of the organ transplant system, divides the country into 11 regions, essentially demarcating borders within which organs move from donor to recipient.

The first legal challenge to the borders in years hit Nov. 19, in Holman's name, spurring an almost-overnight change by the gridlocked organization.

Attorneys filed an emergency complaint against HHS on her behalf. They sought an injunction on UNOS' regional policy that is much-debated but seldom changed.

The Holman lawsuit set in motion a rapid succession of government counter-appeals and new court orders. It culminated in a Thanksgiving-weekend change to a rule on lung allocation, expanding the procurement area to a 250-mile radius around a patient's donor service area.

Transplant surgeons have met this development with mixed reactions. Concern focuses on the role courts may now play in policy for other organs, particularly livers. On Dec. 1, the attorneys that represented Holman sent a letter to HHS acting Secretary Eric Hargan, seeking intervention on behalf of 25-year-old Tamiany de la Rosa, who waits for a liver at Mount Sinai Medical Center in New York City.

De la Rosa is ranked among the very sickest of patients awaiting a liver; she could die within three months if she doesn't get a new one.

Dr. Ryutaro Hirose, a nine-year member of UNOS and former chair of the UNOS liver committee, said the courts aren't the best option to push major change.

But Hirose represents the transplant center at the University of California at San Francisco—California is another region with far more patients than organs—and said he's spent the past several years witnessing the same arguments from the entrenched haves and have-nots of organ allocation without seeing substantive change. Legal action, he said, is "one way of getting things done."

This isn't to say change never happens. In early December, three days after de la Rosa's attorneys sent their letter, UNOS met and approved a new policy expanding access to livers for patients at a certain sickness threshold to within a 150-mile radius of their service area, while boosting priority for local people on the liver waitlist.

The UNOS board also appointed an ad hoc committee of representatives

THE TAKEAWAY

Liver allocation policy pits U.S. regions and major medical centers against one another.

The waiting game

Liver transplants by region, 2016	Donors	Number of people on waitlist	Transplants in 2016
Region 1 Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Eastern Vermont	308	911	348
Region 2 Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania, West Virginia, Northern Virginia	1,172	2,042	1,001
Region 3 Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Puerto Rico	1,392	1,276	1,336
Region 4 Oklahoma, Texas	909	1,666	781
Region 5 Arizona, California, Nevada, New Mexico, Utah	1,277	2,955	1,166
Region 6 Alaska, Hawaii, Idaho, Montana, Oregon, Washington	285	402	222
Region 7 Illinois, Minnesota, North Dakota, South Dakota, Wisconsin	691	1,143	645
Region 8 Colorado, Iowa, Kansas, Missouri, Nebraska, Wyoming	532	1,025	473
Region 9 New York, Western Vermont	372	1,099	404
Region 10 Indiana, Michigan, Ohio	696	991	715
Region 11 Kentucky, North Carolina, South Carolina, Tennessee, Virginia	863	872	750

Source: Health Resources and Services Administration

from each region to look at the geography issue, but their report isn't expected until the spring of 2018.

Given the complexity of liver policy, Hirose said that even a baby step gives him hope.

Nonetheless, the Holman lawsuit is a warning to UNOS. Hirose said he hoped it spurs the committee to make a more drastic policy change in their process "as opposed to judicial mandates or external government regulators."

The more that livers are sent to larger cities instead of smaller transplant centers, the more vulnerable those centers become.

But not everyone is in favor of big change. Dr. George Loss, chief of the Multi-Organ Transplant Institute at Louisiana's Ochsner Health System, agreed with policy critics that this latest tweak won't massively boost the number of livers available in New York. He said transplant centers should deal with their shortage another way: by more aggressively using marginal or "high-risk" livers from outside their regions, which could expand liver availability by as much as 20%.

Use of high-risk livers widens a center's access to livers from outside their UNOS region. This is because they get the first call from organ procurement organizations unable to place damaged livers within their region. A liver must be transplanted within hours of removal, so centers known for using marginal livers get expedited treatment.

There is no definitive measure, or definition, of marginal livers. UNOS compiles data on how many livers are recovered, transplanted or not, and breaks down the reasons why. The most common reasons a liver isn't transplanted are poor organ function or the donor's medical history.

Hirose agreed that organizations ought to be more aggressive in the way they approach liver procurement, including finding new donors, but the argument is very different from the one swirling around changing regional allocation policy.

"The borders were not designed by gerrymandering to make disparities; they were drawn randomly without design or intent to be used as organ distribution areas," he said.

He noted that any big change to allocation rules would hit some centers' profits in a big way. For example, Californians who can afford it, travel to Ochsner to get a transplant.

And some fear that if more livers are sent to larger cities, smaller centers will become vulnerable. "You are potentially trading one disparity for another disparity of access to an actual transplant center," said Joey Boudreaux, chief clinical officer of the Louisiana Organ Procurement Agency.

As stakeholders debate the what-ifs, the waitlists in organ-scarce regions aren't getting shorter and patients like Holman and de la Rosa may spur the courts to draw their own conclusions, and possibly their own boundaries. ●

Hospital execs remain wary of bitcoin as the currency goes mainstream

By Rachel Z. Arndt

If there's one thing healthcare folks know about bitcoin, it's that the cryptocurrency can be used for paying ransom. The poorly understood currency is how many organizations have paid to get their data back from the hackers who sneak into their IT systems and encrypt it.

Meanwhile, outside the industry, bitcoin has gone mainstream, as futures for the cryptocurrency became available for the first time in a big, regulated market. A day after the Cboe Futures Exchange opened the derivatives to trading on Dec. 10, bitcoin futures were up 20%, with bitcoin itself up 1,600% in 2017. The digital currency was worth about $17,000 last week.

But the healthcare industry remains wary of the blockchain-based money, which has long been a mainstay of the dark web, the part of the internet made up of anonymously run websites not indexed by search engines and accessible only through special browsers, such as Tor. There, bitcoin is used to anonymously purchase, among other things, the very data that hackers steal for ransom payable in bitcoin.

Early in 2016, for instance, Hollywood Presbyterian Medical Center in Los Angeles paid $17,000 in bitcoin to hackers to regain access to its IT systems. And in the middle of 2017, hackers demanded $300 in bitcoin from each organization hit by the WannaCry ransomware.

Indeed, paying ransom is a key use for bitcoin, said Dr. Christopher Longhurst, chief information officer at UC San Diego Health.

Security experts recommend not paying ransom, but that's sometimes not an option for organizations crippled by lack of access to their data. "There are more than I would like to see doing it, but I understand why they're doing it—they're doing it because sometimes it's cheaper to pay the ransom than it is to deal with the days being down," said Mac McMillan, CEO of privacy and cybersecurity consulting firm CynergisTek.

To get bitcoin, affected organizations can turn to "several legitimate security firms that can purchase and transact organizations in the event of a ransomware infection," said Adam Malone, director of cybersecurity and privacy for PwC U.S.

Other than that, the currency is not yet very common in healthcare. "It's like any new technology," said Dr. John Halamka, CIO at Beth Israel Deaconess Medical Center in Boston. "There has to be an urgency to change." He wondered what, exactly, healthcare could use bitcoin for. "If we just think of bitcoin as yet another form of foreign currency, I don't think we accept any foreign currencies." But, he said, he could stretch to see bitcoin as a way to make anonymous payments to preserve patient privacy.

"It's like any new technology. There has to be an urgency to change."

Dr. John Halamka
CIO
Beth Israel Deaconess

Some healthcare organizations already accept bitcoin as payment. A New York City cosmetic surgery practice called Bodysculpt, for instance, began accepting bitcoin in November 2017. "The goal is to provide privacy and anonymity for patients," according to a Bodysculpt news release.

But the vast majority of healthcare organizations today don't accept the cryptocurrency. While their interest in bitcoin itself may be minimal, their interest in the technology behind it, on the other hand, has been greater, as startups tout blockchain-based solutions for revenue cycle and even electronic health records.

Blockchain, the technology that supports bitcoin, is essentially a decentralized, open record of transactions. With both finances and patient records, blockchain theoretically allows for greater efficiency and security.

"When done correctly, the general safety and security of blockchain is a lot greater than any other system we have in place," said Brian Becker, an associate in Nixon Peabody's business and finance department.

For EHRs, blockchain could be used to point to all of a patient's records and to changes in those records, opening up data for greater interoperability. "There are obvious benefits to decentralized storage of health information, as long as you can be confident in the security of it," said Michael Morgan, head of McDermott Will and Emery's global privacy and cybersecurity practice. "There's an obvious value proposition in that context."

On the financial side, bitcoin might be used for claims processing and secure payment transactions, as is the case with Change Healthcare's technology, which the company says will make claims processing more efficient.

"There's all kinds of applications for blockchain in terms of providing that peer-to-peer audit that allows you to digitally track the interactions between users and devices," McMillan said. "But the coin itself—I'm not sure. … Bitcoin was created to be able to buy things, and there aren't many businesses today yet that literally buy and sell services over the web using bitcoin." ●

THE TAKEAWAY

Bitcoin futures recently launched on a mainstream exchange. But the healthcare industry has been slow to adopt the cryptocurrency for anything more than paying ransom for breached data.

Calif., N.C. hospitals take biggest hits in 340B cuts

By Alex Kacik

Hospitals in California, North Carolina and New York will feel the most pain from the CMS' plan to trim $1.6 billion from the 340B discount drug program.

Funding cuts next year could range from $1 million in Alaska to $126 million in California, researchers for consultancy Avalere Health found. Providers in New York will see payments drop by $62 million, while North Carolina providers will take a $73 million hit. Overall, hospitals in six states will each see drug payment cuts of more than $50 million.

About 62% of Medicaid disproportionate-share hospitals will experience less than a 5% reduction in Medicare Part B revenue due to the drug cuts, while 6% of impacted hospitals will experience cuts greater than 10%.

But the concurrent increase in non-drug payments will mean that most hospitals will have minimal changes to their revenue, according to the self-funded study. Hospitals with high 340B volumes will likely see the biggest change and any reduction to already thin margins could spell trouble.

Consumers stand to benefit from the cuts, researchers said. Since Medicare beneficiaries are responsible for a portion of the total drug reimbursement, consumers in California, North Carolina and New York would save $32 million, $18 million and $15 million, respectively. Ten states will each have total beneficiary savings of more than $10 million.

340B "has become a big business for hospitals," Avalere President Dan Mendelson said. "As a result, all hospitals in the program have to think about this carefully going into next year."

In a House Energy and Commerce Committee hearing last week, Rep. Dr. Larry Bucshon (R-Ind.) said hospitals could manipulate the program, for instance, by buying a physician practice in a rural area to participate in the 340B program. Mandating more transparency on how hospitals use 340B money would prevent abuse, he said.

"The rules allow the hospitals to pursue these mechanisms aggressively," Mendelson said. "Some members of Congress believe the rules diverge from the original intent of the program as a way to make it easier for low-income individuals to access drugs." ●

THE TAKEAWAY

A new analysis shows that six states will each see drug payment cuts of more than $50 million next year.

2017 The Year in Review

January

Hail to the chief: Donald Trump is sworn in Jan. 20 as the 45th president of the United States. Two days later, he signs an executive order instructing agencies to do what they can to **roll back the Affordable Care Act**.

It's getting hot in here: The Centers for Disease Control and Prevention cancels a climate change conference scheduled for February. The move marks the first significant change in public health policy from the Obama administration, which had stressed the health dangers of ignoring climate change.

Travel ban: Trump signs an executive order banning immigrants from seven Muslim-majority countries from traveling to the U.S., **affecting roughly 15,000 doctors and more than 60,000 healthcare professionals.** The ban gets tangled in the courts for virtually all of 2017.

February

Let's call the whole thing off: After a federal court blocked the deal, Aetna and Humana pull the plug on their proposed marriage.

March

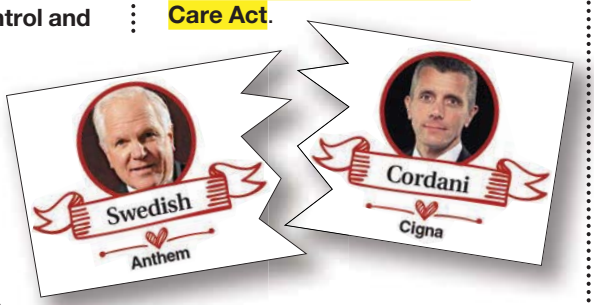
First pass: The president's first fiscal budget request calls for **cutting HHS' funding by nearly 18%** from 2017 levels and eliminating many anti-poverty initiatives.

April

Firm footing: HHS finalizes a rule aimed at **stabilizing the individual insurance market.**

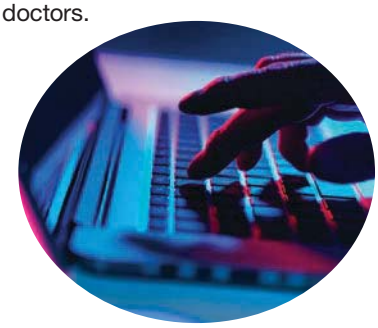
May

Repeal and replace: House Republicans pass a bill to **repeal and replace the Affordable Care Act**.



Let's call the whole thing off, Part 2: Anthem and Cigna abandon their bitter merger talks.

Last in line: Texas becomes the final state to **allow telemedicine visits without in-the-flesh meetings** between patients and doctors.



Cyberwoes: WannaCry ransomware strikes organizations—**including healthcare providers**—worldwide.

One billion: Kaiser Permanente posts a record $1 billion operating gain in the first quarter.

June

Dumping VistA: Veterans Affairs Secretary Dr. David Shulkin awards Cerner Corp. a $10 billion no-bid contract to replace the department's homegrown electronic health record system.

Amazon at the door: The e-retailer quietly builds its business platform and portfolio of medical supplies. Acquisition of Whole Foods fuels talk that it would break into drug distribution, **using the grocery stores as pharmaceutical outlets**.

July

Not so fast: Senate Republicans fail to pass a bill to **repeal and replace the ACA.**

August

Harvey: The Category 4 hurricane slams the Gulf Coast. Houston floods and **several hospitals are forced to evacuate**.

Legal battle: A slew of states sue opioid manufacturers and distributors to recoup money they've spent addressing **the opioid epidemic**.

Merger mania: Carolinas HealthCare System and UNC Health Care agree to **join forces.**

Selloff: Community Health Systems continues its push to shed assets, **announcing plans to sell hospitals** worth $1.5 billion in revenue.

Cost-cutting move: Anthem stops paying for **MRI and CT scans performed on an outpatient basis** at hospitals.

September

Speak now: The CMS issues a request for information asking providers and others to **advise the Center for Medicare and Medicaid Innovation** how it can advance new payment models.

Irma: Florida Gov. Rick Scott calls for **mandatory evacuation** of the Florida Keys as Hurricane Irma bears down.

Maria: Puerto Rico's already fragile health infrastructure is decimated by Hurricane Maria, which leaves **58 of Puerto Rico's 69 hospitals without power** as of the end of the month.

Doctor is out: Use of a private jet for government business forces **HHS Secretary Dr. Tom Price to resign**.

Deadline missed: Congress misses a critical deadline to reauthorize funding for the **Children's Health Insurance Program** and community health centers.

October

Tragedy on the Vegas Strip: **A gunman opens fire** at the Route 91 Harvest country music festival in Las Vegas, **killing 58 people and injuring 546**.

No more money: After writing checks month-by-month, Trump officially **ends cost-sharing reduction payments** to insurers.

CMS road show: CMS officials kick off the Patients over Paperwork initiative. They **travel the country gathering information** on how regulations affect providers and patient care.

Making measures count: The CMS launches the Meaningful Measures initiative, hoping to **focus on outcomes** and reduce administrative burden.

Opioid crisis: Trump declares the **opioid epidemic** a public health emergency.

PBM shakeup: Anthem announces a plan to **team up with CVS Health** to launch its own pharmacy benefit management company.

Shakeup: Tenet Healthcare CEO Trevor Fetter steps down.

November

Cutting 340B: The CMS finalizes a rule slashing hospital payments for the drug discount program by **$1.6 billion**.

Freed from MACRA: The CMS finalizes a rule exempting more small providers from complying with the Merit-based Incentive Payment System. A grand total of **934,000 providers will be exempt** from the new program.

Mandatory no more: The CMS tosses the Episode Payment Models and the Cardiac Rehabilitation Incentive Payment Model. The agency also **lessens the impact** of the Comprehensive Care for Joint Replacement Model.

A taxing plan: Congressional Republicans advance tax reform bills. Provisions would affect tax-exempt financing and the ACA's individual mandate.

Meet the new boss (maybe): Trump nominates Alex Azar to be the next HHS secretary.

December

Here come the disrupters: CVS announces a $69 billion **buyout of Aetna**.

More merger mania: UnitedHealth's Optum agrees to **buy DaVita Medical Group** for $4.9 billion.

Midwest mammoth: Advocate Health Care and Aurora Health Care agree to combine forces. Deal would create **the nation's 10th-largest not-for-profit health system.**

Year-end deal: Dignity Health and Catholic Health Initiatives ink merger agreement. The deal, a year in the making, would create **the nation's largest not-for-profit hospital company** by operating margin.

SPONSORED CONTENT

UNLOCKING THE FULL POTENTIAL OF CLINICAL ASSETS IN THE ERA OF HEALTHCARE REFORM

MODERN HEALTHCARE LEADERSHIP SYMPOSIUM,
OCTOBER 20th, PARADISE VALLEY, AZ

DAVID KLUMPE

President of Clinical Asset Management Solutions, **TRIMEDX**

MARY JO GREGORY

President and CEO, **The Narbha Institute**

VALARIE JACKSON

VP and Exec. Director, **Cole Memorial Hospital**

GREGORY JOHNSON

CEO, **Foundation Health Partners**

SUJA MATHEW

Chair of Medicine, **Cook County Health and Hospitals System**

STEVE PURVES

President & CEO, **Maricopa Medical Center**

HEALTH SYSTEMS ARE UNDER INCREASING PRESSURE to reduce their costs. While many leaders often look to variable costs like labor and supplies, few are honing in on clinical assets like medical equipment, which have a huge impact on cost, quality and patient satisfaction. For example, a health system with $5 billion of annual patient revenue will typically own over 100,000 clinical assets with an associated $100 million of annual capital expenses (CAPEX) and $75 million of annual clinical engineering operating expenses. **Knowing what assets you own and how those assets are actually being utilized is at the root of knowing how to plan and manage both operating and capital costs.** David Klumpe, President of Clinical Asset Management Solutions for TRIMEDX, discussed this topic with five provider executives at the Modern Healthcare Leadership Symposium on October 20, 2017.

KLUMPE: HOW DO YOU BALANCE THE ALLOCATION OF CAPITAL BETWEEN EQUIPMENT AND OTHER DEMANDS IN YOUR ORGANIZATION, INCLUDING FACILITIES, IT SYSTEMS AND STRATEGIC INITIATIVES AROUND POPULATION HEALTH OR SERVICE LINE DEVELOPMENT?

JACKSON: Consulting providers and department managers, we come to a consensus about what we want to put on our wish list and rank it based on the potential for critical failure. Regulatory compliance also comes into play. We do a business case for our board on a monthly basis that presents what we think we need most urgently.

PURVES: We try to make decisions so that we don't have everything due at once, making a reasonable approach to routine capital every year. We have a multidisciplinary technology assessment committee that includes all our clinical chairmen and aims to focus on enterprise-wide solutions. We don't want a Duke's mixture of things in our health systems. I feel very strongly that clinicians need to be an integral part of not only the early evaluation process, but also in decision-making. We're trying to build a care model for where that puck is going to be, not where it is today. Hopefully, we reduce our life cycle costs, or at least increase value, so that we reach more people in the community than we do today.

GREGORY: The learning curve is extraordinary, especially with cybersecurity, new apps and interoperability, which can make it difficult to understand where your danger zones might be. If we're really going to be cutting edge, we need talent who can maintain these assets and ensure we're getting the ROI and interoperability we are promised. I've found that to be a shallow space.

JOHNSON: We're trying to build the health systems of the future. If I can find somebody that can predict with 90% certainty what the future of healthcare is going to look like, I'm going to hire them and I'm going to pay them a lot of money.

KLUMPE: HOW ARE YOU THINKING ABOUT THE EXISTING ASSETS THAT YOU HAVE AND DRIVING THE MOST USEFUL LIFE OUT OF THOSE ASSETS TO STRETCH YOUR DOLLAR?

JACKSON: We have rather siloed processes. Procurement tags the equipment, and then it goes to biomedical engineering, which keeps a running tally of all clinical assets and their condition. During the course of the year, we send out a fixed assets ledger to the department managers who confirm whether they still have the equipment, but there's currently no point at which these two parties say, yes, we have this piece of equipment, but it's aging. Trying to figure out what we
truly need and what we already have that needs to be extended – I think that's where we're lacking in resources.

JOHNSON: The demand on capital priorities is so high – you need a single source of truth so that you know what you have on a daily basis, so that you can make decisions easier.

MATHEW: We see a lot of equipment coming to death at the same time, and are often trying to identify what must be fixed right now. That's the strategy that's been used historically, but we are trying to implement a proactive process for the future so that we are never again be in this situation. I think that is a major challenge.

"The demand on capital priorities is so high – you need a single source of truth so that you know what you have on a daily basis, so that you can make decisions easier."

GREGORY JOHNSON

KLUMPE: WHAT ARE THE STRATEGIES THAT YOU'RE USING TO ACHIEVE STAKEHOLDER ALIGNMENT AROUND DIFFICULT CAPITAL ALLOCATION DECISIONS FOR CLINICAL EQUIPMENT?

PURVES: Stakeholder alignment is absolutely critical for everything else to work. Department leaders need to get out of their silos. It really starts from the top – the leadership must create a support system to enable these departments to do an outstanding job. They need to be supported by a process that allows them to participate together and understand the big picture. The system must enable folks to ask the right questions so they can understand the downstream impact of what an equipment acquisition is going to have on their patients.

JACKSON: I think what we're talking about is your strategic vision for your organization and where you are placing your focus. We've been working with our physicians on a "needs versus wants" conversation. We look at how effectively we are taking care of our patients and how that translates into patient care. We have to ask, is the latest little gadget really going to enhance safety and quality for our patients?

KLUMPE: IF YOUR CLINICAL TEAM IS SAYING, "WE HAVE TO HAVE THIS," WHERE ARE YOU TURNING FOR SUPPORT ON YOUR ANSWER?

MATHEW: Historically, for us, each clinical department has submitted their capital requests, and it seems like it goes to some "magical place." Many months later, when the budget is approved by our health system's board and our county board, we get a list of what's been approved. Last year, we put the department chairs together in the same room and looked through all the capital requests and have a conversation, hoping to address this issue of silos. I think we, as department chair colleagues, absolutely stunned our leadership because we were incredibly collaborative and cooperative, and we really understood the needs of one another. It was a fantastic opportunity for us to give things up in support of our colleagues' requests.

PURVES: Leadership doesn't create the environment to create exactly that collaborative process. You all got in the same room and guess what? You really don't have to do anything. You don't tell anybody what to do. You just sit back and be delighted in the result that comes about from that. We've gotten much smarter about these enterprise-wide capital decisions, which have to link to your strategic plan.

"Stakeholder alignment is absolutely critical for everything else to work. Department leaders need to get out of their silos."

STEVE PURVES

GREGORY: I hate the "I'm taking my Barbie dolls and leaving" attitude. I think that the capability to have an adult conversation and be focused on the whole enterprise and not on that "I must have" kind of thing is really a mission-driven effort, and it doesn't happen overnight. You can't flip the light switch on and say, "change the culture today." It requires a building of trust.

KLUMPE: HOW WOULD YOU SUGGEST AN ORGANIZATION SET UP A COLLABORATIVE PROCESS FOR CLINICAL EQUIPMENT DECISIONS?

PURVES: The very first thing is, create a culture of participation and transparency. The second thing is, you have to develop the enabling resources to allow an approach like that technology assessment committee to be effective. You've got to have professionals and you've got to have an approach that gathers that information so that you can look at it from a big picture standpoint and do something with it. You must understand life cycle cost. It's critical. The service aspect of a purchase can make or break the decision.

KLUMPE: AS YOU WORK WITH YOUR TEAMS TO VET NEW CLINICAL EQUIPMENT PURCHASES, HOW DO YOU WORK WITH THEM TO REMOVE THE OLDER EQUIPMENT FROM YOUR INVENTORY?

JACKSON: There's a bargaining that goes on in our organization. For example, if one of the departments wants to replace their aging ultrasound, and they're

aware that the OB department has an even older ultrasound, they leverage that to buy a new one and give their old ultrasound to the OB department, which still ends up better off. So, we don't have an issue with disposing of the older equipment, but we do have collaboration amongst the organization to look forward.

MATHEW: It's not just about the life of a piece of equipment. There are other considerations. Safety comes first, then quality, and finally, what are the growth areas for our strategic plan?

KLUMPE: WHAT BEST PRACTICES ARE IN YOUR EVALUATION CRITERIA FOR NEW CLINICAL EQUIPMENT DECISIONS?

MATHEW: I like to know what my regional peers are doing. I don't want to dismiss a physician when they say, "I use this equipment at another facility, so I need to be able to use it here." But I'd like to validate that in some way.

KLUMPE: WHAT ARE SOME ASPECTS OF THE DECISION-MAKING PROCESS THAT YOU'D LIKE TO IMPROVE UPON?

JOHNSON: For a lot of these purchases, you're only making a decision once every five or ten years, and the vendors selling these pieces of equipment know that. Sometimes we have a lack of knowledge in the current market – we don't necessarily know what truly are the best systems available – which makes it difficult to make sure we're asking all the right questions. If you don't know the question to ask, there's a good chance you're going to get something other than what you expect.

MATHEW: I think that there's a real opportunity for creating a multidisciplinary committee to really look at the equipment and the technology the organization. I think finding the right leadership for the committee is key, and will be a real challenge for me. But that's a really great way to ensure we have the right skill set and knowledge base around the table, and also helps us understand our priorities a little bit better.

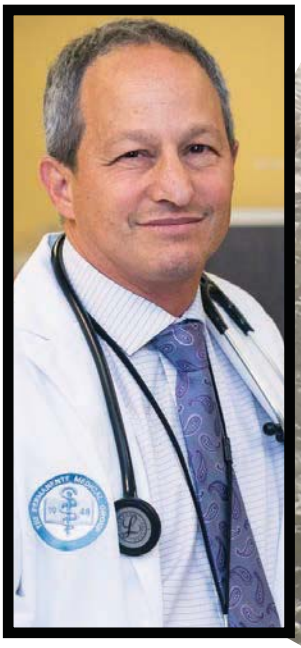
PURVES: It's all about aligning your organization around your strategic plan and engaging people, and being transparent about it. That clears out a lot of impediments, regardless of the organizational mission you're talking about, whether it's capital asset planning, productivity management or your quality and patient safety program. You need to encourage people to get out of their siloes and remove barriers so that ideas can get evaluated rapidly and you can eliminate the "slow no" in an organization, which is a death knell. It's all about leadership effectiveness and accountability and recognizing that your people really have some wonderful ideas. All you've got to do is clear out the bureaucracy and let them do it.

GREGORY: It's important to have transparency so that there isn't a quid pro quo going on when an individual has some kind of relationship with a vendor. That's sometimes hard to identify. But when you have a culture of transparency, it comes out.

"People became selfless." Robert Weiss was referencing his colleagues in Las Vegas who responded to the worst mass shooting in modern U.S. history, but he may as well have been speaking about the entire healthcare system. Unlike any year in recent memory, 2017 tested people's mettle. Many rose to the occasion, often putting themselves in harm's way to, as they said, just do their jobs. As this challenging year comes to a close, Modern Healthcare wanted to share some of their stories.

—As told to Managing Editor Matthew Weinstock

HEROES



Judy Coffey

Senior vice president and area manager

Dr. Josh Weil

Assistant physician in chief
Kaiser Permanente Santa Rosa (Calif.)

Weil: I was working that evening, Oct. 9, in the emergency department and around 1 a.m., I heard some of the radio chatter from the paramedics and realized that there was a structure fire probably within 3 or 4 miles of my house. So I called my wife to say there's some weird stuff happening out there.

About 15 minutes later, I got a call from one of my neighbors who didn't realize I was at work and he said, "You need to get out." I knew exactly what he was talking about. I called Claire, my wife, and my 15-year-old daughter answered the phone. They were in the car and she was just screaming as she, my wife and our dogs were trying to drive off of our property and down the hill through a wall of flames on both sides of the street, burning branches falling in front of them, transformers exploding. It seemed like an eternity, but it was about 30 to 60 seconds until they were able to get out of it. I told them to come to the hospital so I knew that they were OK.

Coffey: All of the homes around me were burning. I was the administrator on call and, had I not actually gotten a call to get the command center up and running, I wouldn't have even known until maybe it was too late.

My husband had just had knee surgery, so I needed to get him up. And our next-door neighbor is 83 and just had a stroke, so I had to get her.

When I got to the hospital, I noticed that the trailer park next to the campus had caught fire. I saw Josh and we opened the command center.

Weil: It was already an unusually busy night when I started my shift around 11 p.m. And it was starting to get busier.

There were roughly 90 patients in the hospital and roughly 30 came in. All told in the end, we evacuated 122 patients, both inpatient and the emergency department.

The firefighters came in at 3:30 in the morning and used the words very, very clearly, I remember them, "We're making a last stand against the fire right now."

We lined everybody up on the first floor of the hospital and identified somebody to stand by every patient; not necessarily a clinical person, but just somebody who would be with every patient.

We had already engaged the county and the city in terms of what we needed for transportation. The majority of patients went to Kaiser Permanente San Rafael.

Weil: There were over 210 Kaiser Permanente staff who lost their homes in Santa Rosa, and a number of them were here that night. Some of them were here when it started. Some of them came in after they lost their homes. But everybody who was here that night faced this unbelievable scenario.

Coffey: We even had an ICU nurse who called his wife and found out that their home was burning. She was 40 weeks pregnant. He told her to go to her mom's house, which is about 19 miles away. He didn't leave; he stayed to help with other patients. There are a lot of stories like that.

Weil: It would have been easy to understand if someone said: Look, I can't stay. I've got to go. I don't know anybody who did. I think every single person stayed to the end to make sure that we got our patients out safely. ●

HEROES

Employees from hospitals across New York wait to board a plane headed to Puerto Rico.

Jenna Mandel-Ricci
Vice president of regulatory and professional affairs
Greater New York Hospital Association
New York City

The storm hit on Sept. 20, a Wednesday. By that weekend, we were part of calls that the governor's office had put together.

There are incredible ties between New York and Puerto Rico and that even applies to many of our member institutions that have significant portions of their employees with personal ties to Puerto Rico; either they're from Puerto Rico or have family there. There was a very personal outcry from hospital employees across the city and state who said, "We need to do more. We need to help."

Because we're sending healthcare providers into a disaster situation, there's life insurance and liability and credentialing issues involved. We had to spend quite a bit of time figuring out the structure through which we were going to send them.

We ended up having a first team of 78 clinical staff going down and then a second team, by luck, was also 78.

Our folks landed in San Juan and within 36 hours they all had assignments and were sent to different places around the island. There were a lot of questions about safety and security and how were they going to get fed, what was the chain of command and how we were going to communicate with them. Remember, this was the beginning of October and the power grid and communications were basically nonexistent.

We had someone on our team who had significant experience with incident command and emergency response. That person became a liaison officer and was embedded in San Juan in the HHS headquarters.

As soon as "Team 1" went down, we started inviting the other team to come in and join our daily calls. They got to listen in for two weeks about what was happening on the ground and were able to really prepare their clinical teams for what they were going to see. That was just invaluable.

Some very cool stuff happened. New York-Presbyterian sent 12 people on the first team and 13 on the second, and they were able to set up a telehealth system. A satellite dish was brought in near the clinic where they were working. They set up a link with Columbia University Medical Center and were able to do peer-to-peer consultations.

"Some very cool stuff happened. New York-Presbyterian sent 12 on the first team and 13 on the second, and they were able to set up a telehealth system."

Clinicians from Jamaica Hospital Medical Center in Queens were embedded with AmeriCorps and stationed in Rincon, which is on the western part of the island. For the whole two weeks they were there, they staffed mobile medical clinics and made home visits to these very remote parts of the island that frankly hadn't seen medical care. So it was incredibly rewarding for them on a personal and professional level.

And I also think it was hard for them to go. They are worried about their patients in New York. They are worried about their families.

Hospitals have been paying a lot of attention to those employees since they got back. ●

Dr. Scott A. Scherr

Regional medical director
TeamHealth Emergency Medicine West Group; chairman of emergency services, Sunrise Hospital and Medical Center, Las Vegas

When I walk into the ED, it's normally just 45 beds. But the day of the shooting we had patients in every single spot of the hallway, every single chair. Every station where one bed would go, we had at least two to three beds.

We utilized station 1, which is our heart trauma resuscitation bay, to directly bed our patients who were triaged red; those are the patients who have seconds or minutes to live. We ended up having 63 patients who were in critical condition. Not all of those were red, many were yellow—those who have an hour or so to live and need some active resuscitation, but didn't need emergency procedures at that time.

We had over 20 physicians and advanced practice clinicians respond to the ED within about an hour to an hour and a half.

We ended up seeing 215 patients that night. Those are the ones who were registered. A lot of people came in with simple shrapnel injuries. They were bandaged and weren't even put into our system.

We have a very special team here in Las Vegas. Sunrise Hospital is a very busy place to work anyway. We've always stressed a team approach and the next-man-up type of mentality. That certainly was displayed that night.

To think that at 10 at night our providers answered the call and came in without question, that was the reason why we saved so many lives that night. If we did not have that response from our team, a lot more lives would have been lost. ●

Robert Weiss

Advanced practice clinician operations manager
TeamHealth Emergency Medicine West Group
Physician assistant
Sunrise Hospital and Medical Center, Las Vegas

My wife and I had seats off to the right of the main stage. The shooting started, I think, during Jason Aldean's third or fourth song.

When that first volley went out, we were not exactly sure what was going on. It sounded like firecrackers. After the second volley of shots, we knew what was happening.

People were ducking down, running, yelling and screaming. We also noticed some people were getting hit by gunfire.

We tried to take a little bit of cover behind our seats, but I made the decision that we needed to try to work our way out of where we were. There was a lull in the gunfire, and we used that as our moment to try and get out. In all honesty, I was focused on making sure my wife and I were safe getting out of where we were.

I also knew it was my role as a physician assistant, clinician and an ER provider to get to a position where I could start rendering aid to any of the wounded. We made our way across to the medical tent—I had noted its location earlier in the concert—and started working.

We had everything. There was a patient outside of the tent on an electric cart with a very unstable chest wound. I had patients with abdominal wounds, extremity wounds, all the way down to sprained ankles and people who were so emotionally distraught that they couldn't process what was going on.

We had random civilians come in and say, "I'm an off-duty firefighter/paramedic from Loma Linda," or, "I'm an ICU nurse from Kansas, what can I do to help?"

That continued at the hospital where every patient we encountered told us the exact same thing when we went to help them: "Go find somebody else who is worse off than I am. I can wait."

In an odd way it was almost heartwarming to see that resurgence of humanity and selflessness from people despite the events that were going on. ●

"We made our way across to the medical tent—**I had noted its location earlier in the concert**—and started working."

HEROES

Cheryl Cotrell, at the podium, and Dr. Thomas Morrison, to her left, were effusive in their praise of clinicians who helped patients during Hurricane Irma.

Dr. Thomas Morrison

Director of emergency medicine

Cheryl Cotrell

Chief nursing officer
Mariners Hospital and Fishermen's Community Hospital, Florida Keys
Baptist Health South Florida

Cotrell: Because we are a coastal island, if a hurricane is a Category 2 storm or above, we will evacuate the Keys, which is different from other hospitals on the mainland.

Irma was such a large storm, we knew that all of the Keys would be impacted.

I did not plan on evacuating. I have a concrete house and it's 18 feet above sea level in high tide.

D. Wayne Brackin, COO of Baptist Health, called and said, "I will be down to pick you up in half an hour and you will come with me."

OK. He's my boss. I will go, but I have (family here), so that was hard because you didn't always have communications.

Morrison: We targeted Fishermen's for evacuation first because it was close to the impact.

Cotrell: And all of the clinical staff stayed until the last patient was evacuated.

Morrison: Even longer because we wanted to keep the ER open as long as possible.

Cotrell: That's the hard part for people in the mainland to understand. When it's a mandatory evacuation, you cannot demand that your staff stay. Most of them do, but if they live in a mobile home, those are the ones who are always evacuated first and we have to figure out how to either provide them shelter until we can close the EDs, or let them go. We just rearrange schedules and people voluntarily shift and decide that they will cover for someone so they can secure their homes and then come back in and work.

Morrison: We walked through Fishermen's that following Monday morning. You could see cracks in the hallway walls, and there was also some damage from underground. I understand it's an open debate whether that was water or sewage, but it doesn't matter, it's damage.

We set up our own MASH unit, which is made up of containers that are attached to each other. It's better than a tent, but it is far from ideal.

I'm really proud of my docs and nurses who worked there. They really rose to the occasion even though they were out of their element because they're normally medical-surgical or oncology or outpatient. Emergency medicine is very different, but they made it work.

What really impresses me is the impact we've had. Lives were saved because of that facility.

Cotrell: We saw a fair amount of heart attacks and strokes. We provided top-level care without a lot of extra things that doctors rely on now. We only had basic lab, basic X-ray, respiratory and EKG and we had the pharmacist there, which was helpful, but the physicians had to go back to being good clinical diagnosticians because they couldn't say I want a CAT scan or an MRI, because they weren't there.

"We provided top-level care **without a lot of extra things** that doctors rely on now."

Morrison: We had a patient with a ruptured aortic aneurysm. We did not have any tools to make that diagnosis. When I sent him out via helicopter, I thought either he is bleeding out in his gut, or he has a kidney stone. I hoped I didn't overcall it, and we didn't. He was in the hospital for 47 days, had several repairs and came back to thank us.

That kind of stuff makes it all worthwhile.

Pastoral care really came forward too, and they were there for people, not just in the setting of prayer, but in the setting of support. "Let me get you the FEMA number. No, let me get you the FEMA person and bring them to your house." And they orchestrated cleanups where Baptist employees got together, loaded up a bus and would go to people's houses to clear them out.

That was very impactful. ●

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HEROES

D. Wayne Brackin, center in black jacket, and the Baptist Health South Florida command center staff coordinate operations during Hurricane Irma.

D. Wayne Brackin

Executive vice president and chief operating officer
Baptist Health South Florida
Coral Gables

Hurricane Irma was going to be big and potentially catastrophic. I think that was causing a lot of people in South Florida to flash back to Hurricane Andrew in 1992.

It's not just getting through the storm, it is the aftermath; the aftermath of Andrew was a huge dislocation. The severely damaged economy and population shift really altered the southern part of the county.

I caught myself jumping ahead to the aftermath, which is really not helpful when you're right in the midst of trying to get ready for what was about to happen.

We evacuated the two hospitals in the Keys, which were under a mandatory evacuation.

I haven't really told this tale yet, but we have one chief nursing officer, Cheryl Cotrell at Mariners Hospital and Fishermen's Community Hospital, who's lived in the Keys most of her life. The other chief nursing officers got in touch with me and told me that she had not evacuated; she was down there partly for some family issues.

I was at Homestead Hospital, the closest mainland hospital to the Keys. I called her and spent an hour or two trying to persuade her that she needed to get out of there.

I ended up driving down there myself. It was a harrowing drive. To be honest with you, I was about halfway down there and I started wondering if it was a good idea. There's a two-lane, 18-mile stretch that connects the mainland to the Keys. At best, it is at sea level. A couple of times big waves slammed into my car.

When I arrived, Cotrell was standing there with her little suitcase, and we drove around all kinds of debris and crap to get out.

After the storm, we were able to secure a civilian version of a Black Hawk helicopter through the governor's office and they took myself, the chief medical officer for Fishermen's and Mariners hospitals, the CNO and some engineers down to do a quick assessment.

You could see destruction from the air starting from Key Largo, and the farther south we traveled the worse it looked. By the time we got to Islamorada, it started to be Andrew-level devastation.

At Fishermen's hospital, boats had washed up all around the back of the facility. Mariners was built to take a very significant storm surge. The grounds were in ruins, but the building itself looked fairly intact.

Even though the hospital was closed, **we started seeing patients in the parking lot.**

Even though the hospital was closed, we started seeing patients in the parking lot. We were able to treat those patients and then evacuate them out of there.

Between Hurricanes Harvey, Irma and Maria, it's easy for people to move on to the next thing. But there's still a very significant need in the Keys. And we're meeting it. We have two of the three hospitals there. But one of them, in the middle Keys, is still a field hospital and a temporary facility. So you know the aftermath will go on for some time. It's just a reminder that people are still in need and if you can help them, you should. ●

Melissa Santoro

Director of food and nutrition services
Memorial Regional Hospital
Hollywood, Fla.

Normally, we serve about 2,500 meals a day. The first day of Hurricane Irma, we ended up serving over 18,000 meals.

We also provided day care for our employees who sheltered with us during the storm so they didn't have to leave their children. And we had first responders who sheltered with us.

Early in the morning, there were probably 20 police officers down by the ER. The first thing they wanted when the cafeteria opened was to get a hot meal.

It's amazing to see them out on the roads; they're working in inclement weather. We sent meals out to them. We gave them water. We did whatever it took.

When you're sheltered in, everybody's nerves are a little high. Our production is 24/7. But what was incredible during this storm … I went to our command center and said, "Look, we're going to need a little help. We need some volunteers to come down and help make some sandwiches."

I had the head of anesthesia and the head of our physician intensivist program show up with their teams. There were no lines or delineation. Everybody was there to help us because they realized that we were struggling to get these 18,000 meals prepared. I had so many volunteers coming down, and it was just incredible.

Several years ago, I had to report to the hospital when we were preparing for Hurricane Wilma. One of my dear friends said to me, "Why are you reporting to the hospital? You don't take care of patients, you're not a nurse not a doctor."

I looked at the individual and I said, "I'm responsible for all the food and water that comes into the facility." And they stared at me. There wasn't that connection. People forget about the whole support team that keeps the building running. ●

Daryl Tol

President and CEO
Florida Hospital
Orlando

The day after (Hurricane Maria) hit, I started to hear from our team. I got emails from many individuals who had family impacted that they weren't hearing from them. They were fearful. They were concerned.

People started developing an energy to do something and that was tremendous. It started most specifically with an initial group of emergency physicians and emergency residents who decided they needed to be the first on the ground. We started to coordinate logistics with them.

A reporter from Cox Media, our ABC affiliate, who is from Puerto Rico and was on the ground, started talking with our physicians. The affiliate joined forces with us, and to have that public access point to get the whole community rallying behind a cause like Puerto Rico was critical.

We were able to get great media coverage and mobilize the community to come out. In addition to regular gathering points, we did two big Sunday events where it was well-publicized—kind of blasted out across our community—and gathered many containers and truckloads full of materials for Puerto Rico.

I can tell you that in the first few days of these activities, I didn't even really think about the cost side. I actually had physicians and others express later how surprised they were that we were just rolling. They expected us to be setting some limits and trying to manage expenses. Later on, we did set some fairly generous guidelines, and we stayed well within those.

But the fact is that something that's tremendously helpful to Puerto Rico after a storm is well within our capability to provide without harming the organization. And we have a bias for generosity. It's just kind of part of our wiring. ●

HEROES

Kelli Nations

Chief nursing executive
HCA Gulf Coast Division
Houston

We were working with StormGeo, our personal group of meteorologists, who told us in the weeks prior to the storm hitting that we were going to have 48 inches of rain in Houston.

The first thing is to identify the hospitals that we think we're going to have to completely evacuate; that's our No. 1 priority. Simultaneously, we are deploying generators, water tanks, extra linens, additional food, medications—really anything that our hospitals would need so that if they became an island for anywhere from five to seven days, they would be prepared to take care of our patients.

Normally, when you have a hurricane, they come through, you have wind damage and you may have high water, but it is a relatively quick event. With Hurricane Harvey, it just rained and rained. And after the rain and the floods, the reservoirs flooded. It was just such a long disaster; it really tested your resources and your team.

That Saturday night, when we were still taking care of our hospitals and the waters were rising, I was on a call with Jane Englebright, chief nursing officer for the entire company, and I will not forget this, she asked me, "Kelli, how many nurses do you think you are going to need at the end of the storm?"

I wasn't even thinking that far out because I was so busy caring for our patients and what we were dealing with at the time.

Under the support of Jane and her team at the corporate command center, they were able to mobilize nurses. So by that Thursday after the storm, 100 nurses were brought to the greater Houston area. They came to Dallas and were deployed by buses and helicopters to a central location, Conroe Regional Medical Center, which is on the north side of town and had the least amount of flooding. Thursday, Friday, Saturday and Sunday, they continued to arrive. Over that four-day period, we had over 300 nurses come.

Our nurses were so excited. **They would come out to the helicopter to greet the volunteers** with gift baskets and would take pictures by the helicopter. The visiting nurses were fresh and revived and excited about being there.

Our nurses were so excited. They would come out to the helicopter to greet the volunteers with gift baskets and would take pictures by the helicopter. The visiting nurses were fresh and revived and excited about being there.

As they arrived, we were allowed to send our nurses home to care for their families and to check on their homes.

We have over 1,700 employees who received assistance from our HCA Hope Fund. A lot of nurses and staff members lost their home or lost their home and their vehicles.

You can imagine, when they came home from work and had to deal with a home that was flooded, they needed some time off. Many of those volunteer nurses stayed with us for two weeks, even four weeks, to allow our nurses to take some needed time off to care for their families and get back on track. ●

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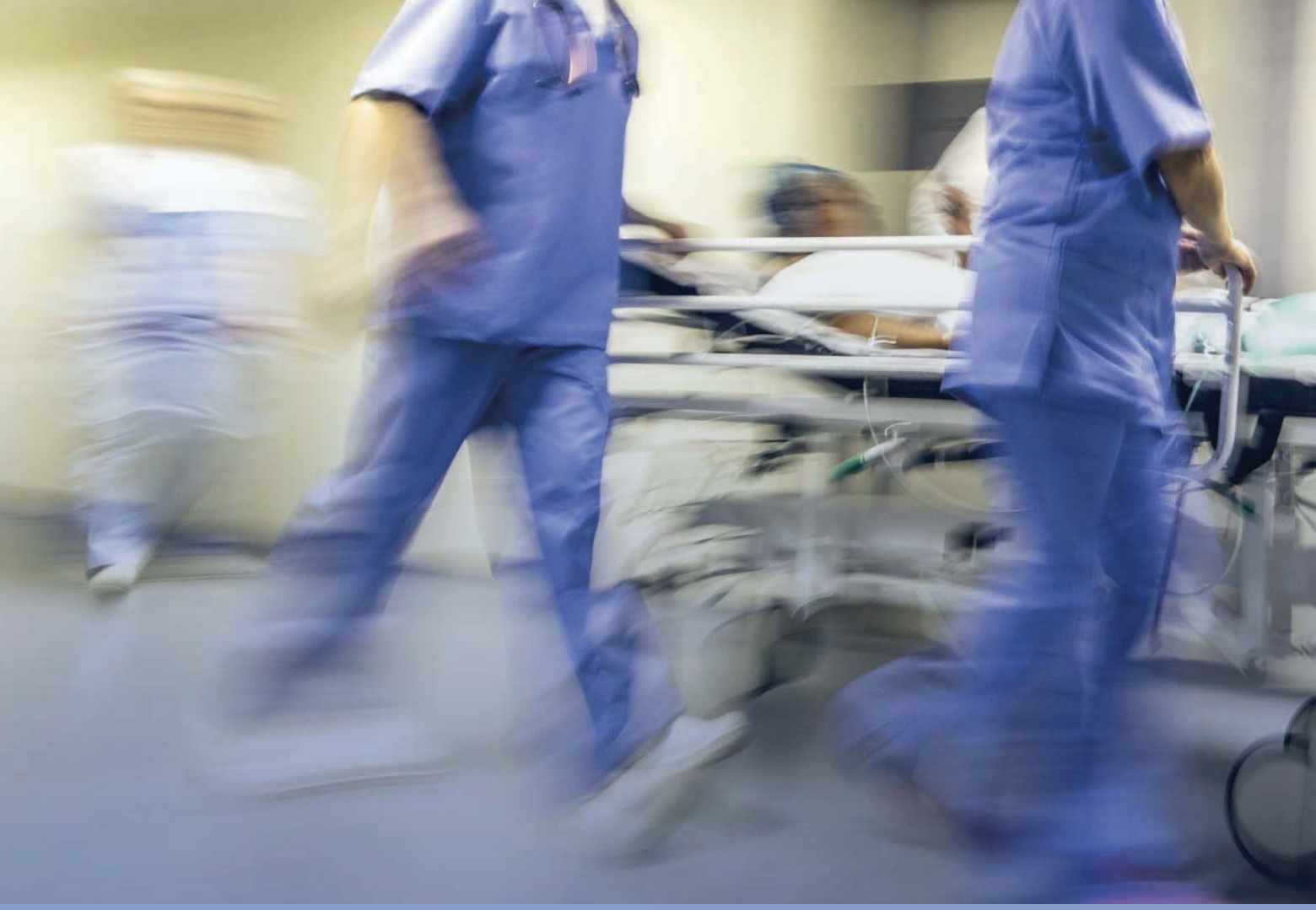

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Advancing Health in America

An alcohol-free toast to 2018

MERRILL GOOZNER *Editor Emeritus*

'Tis the season of miracles. A year that began with lumps of coal for the healthcare industry ends with Christmas presents wrapped in ribbons of cautious optimism.

The Affordable Care Act still stands. Medicaid has not been undermined. And the drive to improve quality and lower costs—a cornerstone of healthcare policy for the past decade—remains largely intact.

The surprising victory by Democrat Doug Jones in Alabama's Senate race creates an all-but-insurmountable barrier for Republicans still seeking to dismantle the insurance and Medicaid expansions contained in the ACA. And while the tax legislation still repeals the individual mandate, Republican Sen. Susan Collins of Maine has conditioned her vote on renewing the cost-sharing subsidies that make ACA-compliant plans affordable for millions of low-income individuals.

Other moderate Republicans are beginning to make their voices heard. Rep. Greg Walden of Oregon insisted last week that Congress include reauthorization of the Children's Health Insurance Program in the stop-gap government funding bill that must pass before year-end.

But avoiding worst-case scenarios is no reason to break out the Champagne as we make the turn into the new year. While the final tallies from this year's truncated open-enrollment season are not yet known, the likely outcome is several million fewer people signing up for plans. For the first time in our history, the drive to provide universal coverage for all Americans will have suffered a deliberate, policy-driven setback.

Declining enrollment will create individual insurance markets in many states that are smaller and sicker than 2017. This will set the stage for another round of double-digit premium increases next year, and provide grist for the mills of politicians still intent on "repealing and replacing" the ACA.

It will also spill over into larger-than-expected increases in the employer-provided insurance market. Rising uninsured rates inevitably lead to higher uncompensated-care costs among the nation's providers, which eventually get passed along to the fully insured.

However, there will be a countervailing force as America heads toward the midterm plebiscite on the presidency of Donald Trump. Alabama's election results have dramatically shifted the debate over healthcare coverage to the left.

It comes on the heels of a major shift in public opinion that took place during this year's assault on the ACA. The top line of the latest Kaiser Family Foundation tracking poll, released in mid-November, revealed a public marginally supportive of the law—50% in favor compared with 46% opposed.

But that reverses the nation's mood from a year ago, when a plurality opposed the law. And percolating below the surface is a surprising surge in public support for greater government involvement in the provision of healthcare.

When asked last month if adults at any age should be allowed to pay a premium to join Medicare, fully 72%, including a majority of Republicans, said yes. When the question was limited to allowing buy-in for people between 50 and 64, the number approving rose to 77%.

Even when cautioned that this public option would give government more control over healthcare and reduce payments to providers, 58% still supported this movement toward "Medicare for all." And when offered the positive spin that it would be more affordable than ACA plans and make it easier to extend coverage to rural and hard-to-insure areas, opposition dropped to less than 20%.

Want more? Well over half the population now views terms like "Medicare for all," "universal health coverage," and "national health plan" very or somewhat favorably, compared with just a third of the population who are very or somewhat negative about those concepts. Even "single payer" garners a 48%-to-32% plurality with the rest undecided or refusing to answer.

Last week's election in Alabama—one of the most conservative states in the nation—has set the stage for a very interesting primary season for both political parties. Happy New Year! ●

‘Repeal and replace’ is now ‘co-opt and confuse’; let’s focus on real patient-centered care

By Dr. Ann Hwang

Congressional Republicans are still actively trying to dismantle the Affordable Care Act, most recently folding repeal of the individual mandate into the tax reform bill.

But what fewer observers may realize is that the Trump administration is also pursuing troubling new directions in healthcare in other, less obvious places.

Recently they’ve turned their attention to the Center for Medicare and Medicaid Innovation, the agency created by the ACA to test new models for healthcare payment and delivery. This time, instead of “repeal and replace,” the strategy appears to be “co-opt and confuse.”

The administration wants to take the center’s critical work down a concerning new path. Specifically, the CMMI recently requested public comment on a new direction that would “promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers.”

At first glance, this sounds hopeful, especially for those of us who are passionate about patient-centered care—by which we mean the movement to ensure that people and families are the focus of healthcare policy, programs and care. The new direction may not be as positive as it sounds, however, notably for the large number of people with complex health and social needs who rely on Medicaid and Medicare.

While empowerment is generally a good thing, this new proposal for the CMMI hints at a strategy that places responsibility on patients and families to act as “super shoppers,” scouring the healthcare marketplace for good deals on hip replacements and MRIs, using the power of their pocketbooks to bend the healthcare cost curve. But as most of us already know, finding the right doctor can be challenging enough. Finding medical price information—much less comparing multiple prices—is difficult, if not impossible, and a very different thing from savvy price comparison on shoes or smartphones.

Dr. Ann Hwang is director of the Center for Consumer Engagement in Health Innovation at Community Catalyst and a primary-care physician.

Why? First, there may not be a lot of choice to begin with, given that many parts of the country, especially some rural areas, have few options. For other people, with little disposable income for travel or mobility challenges due to frailty or disability, it may be a huge burden to go far from home to find an alternative source of care.

Then there’s the difficulty of obtaining any kind of price information. A recent report card from Altarum that graded states on price transparency and physician quality reporting gave F’s to 48 out of 50 states on one or both measures. A 2016 Health Care Cost Institute analysis suggests that less than 10% of consumers’ out-of-pocket healthcare expenses are for services that are even “shoppable” at all.

In this context, terms like “patient-centered care,” “patient engagement” and “patient empowerment” too often serve as misleading code words for policy prescriptions that actually impose more cost sharing, premium contributions or work requirements on vulnerable families. For people with complex health needs, these approaches are particularly worrisome. There is ample evidence that imposing even small out-of-pocket costs reduces access to care, particularly for people with low incomes or chronic illnesses. In Wisconsin, for example, the addition of a $10 monthly premium made Medicaid beneficiaries more likely to drop out of the program. Numerous studies also link increased premiums to lower health insurance enrollment for poor children.

More person-centered care—the kind we’re advocating with the CMMI and across the country—means creating strong and sustainable mechanisms for consumer engagement, ensuring robust oversight, addressing the social determinants of health, valuing primary and preventive care and addressing the needs of people with complex health conditions. This is good for the healthcare system and for all of us. But it only happens when we value the consumer voice and then listen to and act on what people using the health system have to say to improve their care and make our system more equitable.

People with complex health and social needs should have a greater role in improving our healthcare system—not as customers at the healthcare mall but as full partners in the larger discussion about our care and how it is delivered. ●

Interested in submitting a Guest Expert op-ed?
View guidelines at **modernhealthcare.com/op-ed.**
Send drafts to Assistant Managing Editor David May at dmay@modernhealthcare.com.

Access to laboratory medicine in jeopardy under PAMA payment-setting process

Regarding the article "Tired of talking, labs sue CMS over planned cuts" (ModernHealthcare.com, Dec. 11), although the HHS inspector general initially estimated the rule would apply to approximately 12,000 laboratories, only about 2,000 reported data. The lack of data from labs, combined with the complexity of the fees, resulted in an inaccurate basis to reach sound policy.

There are many different types of labs—hospital, physician office, public health and more. But only commercial labs were allowed to report. CMS' regulations actually prohibited virtually all hospital labs from reporting their payer rates, though Congress explicitly wanted the Protecting Access to Medicare Act of 2014 to reflect the entire market.

At my company, BioReference Laboratories, we have more than 1,800 unique commercial payer groups that qualified for PAMA reporting, reflecting the scale and diversity of the fee schedule and data required for an accurate payment system.

As a pathologist and a healthcare leader, I appreciate articles that help raise awareness around PAMA and the impact that we anticipate the fee changes will have on access to the most powerful and cost-efficient diagnostic tools of 21st century healthcare. The majority of physicians' treatment decisions are made from laboratory data. Limiting access to laboratory testing will have a negative impact on the health of many Americans.

I commend the American Clinical Laboratory Association for bringing greater awareness to the public and urge more providers and health institutions to stand with us and demand that the CMS rethink the new payment schedule before it's too late.

Dr. Gregory S. Henderson
President
BioReference Laboratories

Better care coordination is best path to lower costs

Regarding the Dec. 11 editorial ("Financial engineering isn't going to solve healthcare's cost woes," p. 26), the key point is this: "What none of these deals address is how to marshal resources within new organizational forms to improve care coordination and move upstream into prevention and better population health management."

The system must begin to invest by paying for care coordination that ultimately results in better care and lower costs. An example is the care coordination ensuring that a diabetic has the transportation to clinical visits with a primary-care doctor versus not providing the transportation and ultimately paying for a more expensive trip to the emergency department.

Roger Harrell
Health officer
Dorchester County Health Department
Cambridge, Md.

news makers

Duke's Sowers tapped to lead Johns Hopkins Health System

Who: Kevin Sowers

New role: Named president of Johns Hopkins Health System in Baltimore, replacing Ronald Peterson, who is retiring after 44 years in academic medicine. Sowers starts Feb. 1.

Background: Sowers joins Johns Hopkins from Duke University Hospital. He's been with the Durham, N.C.-based organization for 32 years, the last eight as president.

Pay grades: Sowers was paid $725,000 in reportable and other income by Duke in the year ended June 30, 2016, while Peterson was paid $2.6 million in reportable and other income, according to Internal Revenue Service Form 990s.

Financial challenges: Sowers is inheriting an organization on a less-than-stellar financial footing. The system reported a 26% drop in net operating income to $33.7 million in its fiscal first quarter ended Sept. 30, compared with the year-ago period. In the year ended June 30, 2016, operating income fell 36.9% to $153.2 million.

PEOPLE ON THE MOVE

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CORPORATE

Modern Healthcare, *Chicago, IL*

Modern Healthcare is pleased to welcome ***Tara Bannow,*** who covers hospital finance for Modern Healthcare in Chicago. She previously covered all aspects of healthcare for The Bulletin, a daily newspaper in Bend, Oregon. Prior to that, Tara covered higher education for the Iowa City Press-Citizen. She earned a bachelor's degree in journalism in from the University of Minnesota.

Modern Healthcare

HEALTHCARE BUSINESS SOLUTIONS

Accumen Inc., *San Diego, CA*

Tom Fountain joined Accumen Inc., a leading healthcare performance delivery partner, as Chief Technology and Strategy Officer. In this capacity, he aligns Accumen's technology solutions with hospital and health system laboratory partners to help deliver better quality of care with greater speed and efficiency.

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best practices

OSF Medical Group adopts team-based approach across clinics

By Maria Castellucci

When Susan Schmitz took her blood pressure at home one day this year, she was alarmed by the high reading.

She called her local doctor's office, OSF Medical Group–Guilford Square in Rockford, Ill., to see if she could be examined that day.

The doctor had a jam-packed schedule, but Tina Pumilia, a registered nurse, was available.

Pumilia "was able to see me straightaway, and I wasn't rushed at all," Schmitz said, noting that her blood pressure went down during the exam. "She put me at ease. It made a huge difference."

Schmitz's experience is part of a team-based model of care that has been in place since 2015 across 40 of OSF Medical Group's Illinois clinics. Dubbed the Care Transformation initiative, it involves a multidisciplinary team of clinicians who divide the work in order to see more patients, better treat complex conditions and provide more preventive services.

"We recognized the need to improve upon and redefine our care models so we can really show the results of population health in our ambulatory space," said Dr. Jeffry Tillery, CEO of OSF Medical Group, which includes more than 650 primary-care doctors.

As part of the initiative, each clinic's team includes at least one physician, nurse, nurse practitioner, social worker, care manager and medical assistant.

Every morning the team huddles for about 15 minutes to go over the day's agenda. Quality metrics are discussed as well, including measures that need to be improved upon.

The medical assistant works closely with the physician throughout the day to address patients' preventive needs. Prior to seeing the doctor, the patient will see the medical assistant to discuss any vaccinations or screenings like mammograms or colonoscopies they might need.

STRATEGIES

Huddle each morning to go over the day's agenda and the current status on important quality measures.

Enlist medical assistants to meet with patients so they can schedule important preventive screenings and vaccinations.

Allow nurses to meet with patients who need to be treated for common ailments like urinary-tract infections or strep throat.

All 40 OSF clinics in the initiative have reached the goal of vaccinating 78% of eligible patients for pneumococcal pneumonia. Team-based care has other benefits as well. A study published in JAMA last year showed the model vastly improved screening for depression and adherence to diabetes protocols.

Physicians, such as Dr. Michael Maloney at OSF Medical Group–Guilford Square, say it helps them focus on the patient's main problems and concerns.

Near the end of the patient visit, Maloney goes through all the preventive tests and consults with the patient on why the suggested tests are needed.

Nurses are also used extensively under the model so the clinic can see more patients. If a patient calls for an appointment to treat common ailments like a urinary-tract infection or strep throat, an appointment is made with a nurse instead of a physician.

Nurses are also used if the physician or advanced practitioner ordered a follow-up appointment in a few weeks for a complex patient but it only requires a quick check-in to discuss how they are managing their disease.

"We are able to offload some of these appointments that are appropriate for the nurse clinic—it has improved our access," Maloney said. He sees about 18 to 21 patients per day at the clinic.

Pumilia, the nurse at OSF Medical Group–Guilford Square, has taken on side projects as well. For example, she is currently going through the electronic health records to identify Medicare patients who haven't yet had their annual wellness visit. She calls patients to remind them of the benefit of annual exams and encourages them to set up an appointment.

The visit "is so comprehensive—I spend an hour with them going over every aspect of their life and educating them about ways to keep them from getting sick," Pumilia said.

Since OSF Medical Group–Guilford Square kicked off the Care Transformation initiative in January, Pumilia said she's felt like she can really practice to her full capacity. "It really makes a difference to feel like there is a team behind me."

Maloney said the daily huddles took some getting used to. The staff now has to come in 15 minutes earlier. "But once we started huddling, very quickly we saw the value in it," he said.

OSF Medical Group plans to expand the Care Transformation initiative to its remaining 29 clinics by April 2018. ●

data points

Dial 9-1-1

When tragedy strikes, it's the nation's paramedics and emergency medical technicians who are typically first on the scene to deliver care and try to save lives. And 2017 certainly put the emergency medical services workforce to the test, with multiple natural disasters and another string of mass shootings, all on top of the everyday medical emergencies and carnage from traffic accidents and urban violence.

248,000 Number of **EMT and paramedic jobs** in 2016

$32,670 PER YEAR
Median annual pay for EMTs, paramedics

37,400 **Projected increase in jobs** from 2016 to 2026, representing a 15% increase, much higher than the national average for estimated job growth

—U.S. Bureau of Labor Statistics

37 MILLION
Average number of calls EMS professionals respond to annually

21,283
Estimated number of **EMS agencies** nationwide

8,459
Number of **EMS medical directors**—physicians who provide oversight to EMS agencies

81,295
Number of EMS vehicles, including ambulances, helicopters and fire trucks

—National Association of Emergency Medical Technicians

Arrival at the ED

141.4 MILLION **Annual number of visits** to hospital EDs

11.2 MILLION Number of ED visits **resulting in hospital admission**

13.9% Percentage of **ED arrivals by ambulance** for patients overall.

31.5% Percentage of ED arrivals by ambulance for **patients age 65 and older.**

—National Center for Health Statistics, National Hospital Ambulatory Medical Care Survey

Q&A

‘I want to make AMGA stronger, more powerful, more relevant’

Dr. Jerry Penso took the helm at AMGA in early October, succeeding Donald Fisher, who passed away earlier in the year. Fisher ran the organization for 37 years. Penso wants to build on Fisher’s legacy and believes that group medical practices are ideally positioned to lead the nation in the migration from fee-for-service to a value-based payment and care environment. Penso spoke with Modern Healthcare Managing Editor Matthew Weinstock. The following is an edited transcript.

Modern Healthcare: You replaced someone who had been at AMGA for a long time, and unfortunately passed away, to create that void. What are some of your thoughts about how you’d like to lead the organization?

Dr. Jerry Penso: Don Fisher was an incredible leader who changed American healthcare. He emphasized that the delivery system matters and that the delivery system that emphasizes coordinated multispecialty care is the preferred system of care. During his tenure at AMGA, he saw that model of care go from being on the sidelines to being seen as the preferred model of care throughout the nation, and that is his legacy.

I am so fortunate to have that foundation. So, what I see is an opportunity to take AMGA—450 members, 175,000 physicians treating 1 in 3 Americans—and make it even stronger; to make us the preferred national partner for our members and those who should be our members, in moving along in this journey toward value and toward high-performance health.

MH: As you think about trying to position AMGA in that way and grow your membership, what kind of things are you hearing from the industry? What are they missing and what can AMGA offer?

Penso: I want to make AMGA stronger, more powerful, more relevant. On the stronger point, we want our members more engaged. There are so many opportunities through our education programs, our meetings, our benchmarking program, that members can utilize.

The second thing is I want us to be more powerful. We want to take our value agenda to Capitol Hill, leveraging the strength of our membership, but really using our members and our communication channels to amplify the message that we have more impact.

And finally, we want to be relevant. We want our advocacy work to make a difference in the lives of our members, their physicians and their patients. We do that through our quality programs and through our education programs that work not only with the leaders of these organizations, but further into their organizations with their physician leaders, with their nursing leaders, their pharmacy leaders, so we can actually help them learn as fast as possible how to deliver higher-value care.

MH: All associations in D.C. run into this. You have members who are part of multiple organizations and associations. How do you continue to differentiate what you do and ensure that members still get value out of AMGA?

Penso: First of all, we have a diverse group of members. We have members who are affiliated with hospital systems. We have independent groups. We have academic groups and we have groups that are part of for-profit systems. It’s important that we find areas that unify us and where all these groups can find value. Our overall focus, though, is on the ambulatory group practice side of the equation.

MH: Let’s delve into the value equation. The Trump administration has tapped the brakes on the move to alternative payment models, certainly from a mandatory status. Where does AMGA sit on that particular agenda?

Penso: The current administration doesn’t talk as much about value as the previous administration and one of their priority areas is decreasing the regulatory burden on physicians and providers. We fully support that. So what we’ve done is pivot our priority to developing regulatory relief policies that reward value-based providers. Our focus in working with this administration is emphasizing that value is inevitable, but we can do it through the lens of regulatory relief.

The other issue that we think is beneficial is that the previous administration did push, perhaps even too fast, on some of the initiatives toward moving to value. It takes time for these organizations to retool. Fee-for-service will be unsustainable, but it takes time to develop the culture, the policies, the information technology, the human resources, the care coordination. You can't just turn that on a dime. We will work with this administration to help our groups make that transition successfully by making sure that the programs are ready for prime time.

MH: Let's talk a little about MACRA. What's your sense of your membership and how prepared they are for MACRA?

Penso: I would say, in general, our members are ready. They are organized, remember, in a way that allows them to be accountable for a population. They'll have primary care and specialty care, often they'll have, if not a formal, then an informal relationship with their local hospitals and post-acute care settings. They have the information technology systems. They have the care coordination systems and they have the strong community ties because of their size that have made them understand how to partner effectively. If you put all of that together, they are ready for this transition. I think the question is how do we catalyze this, how do we add the right ingredients so that this can move forward more rapidly?

MH: A related topic is quality measures and metrics. What's your sense of the need for the system to retool, or at least rethink, how metrics are done?

Penso: I have spent years working on this, both as a practicing physician at Sharp Rees-Stealy Medical Group in San Diego, and I lead AMGA's quality and population health programs. I also meet with our quality collaboratives, which are anywhere from 20 to 40 AMGA members focused on improving outcomes in a specific condition, so I think I have a good handle on what works with measurements to move the needle to get better outcomes.

No. 1, less is often more. You need to have fewer measures, ones that are meaningful to the providers and their patients to get the best outcomes. In our best practices collaboratives, we set a rule that we are only going to have three measures maximum on each of those collaboratives that work to improve care.

For example, working on adult vaccines, there are a number of vaccines that we could move the needle on, but we focus just on two: flu and pneumonia. We did a small collaborative with just seven of our members and within a year, we improved dramatically with 190,000 vaccines given that wouldn't have been given without that program. Because of that, we have expanded that to 40 groups and my guess is we'll have in the millions of patients getting vaccines for pneumonia and flu that wouldn't have gotten it. ●

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Diane Francis, senior director of field health economics & market access at the Johnson & Johnson Medical Devices Companies, led a Nov. 15 webinar that offered real-life examples of how leading health systems use this approach.

The entire webinar can be accessed at modernhealthcare.com/caredeliveryinnovation.

1

Real-world evidence is essential to accelerate value-based care

As more providers engage in value-based models, there's an increasing demand for evidence-based best practices that are proven to improve outcomes and costs. Many providers are equipping their teams with data and insights regarding quality and cost to enhance decision making and enable population health management. Today, healthcare organizations have access to significant amounts of data, but not all providers have been able to fully leverage the data to innovate care delivery.

2

The focus of evidence generation is shifting

Traditionally, real-world evidence generation related to medical devices has focused on evaluating safety and effectiveness of new technologies. Increasingly, however, real-world evidence is being gathered and applied to optimize the entire care pathway across inpatient and outpatient settings. Rather than looking at a single point in a case, like surgery, researchers are using predictive analytics to understand how patients' specific needs can be addressed throughout treatment.

3

New opportunities abound for providers that integrate multiple data sources

Most health systems are making significant investments in information systems that enable them to link electronic health records, financial and supply chain systems, and diagnostics into a single data repository. Some health systems are linking additional data sources, including wearable technologies and other platforms that enable telehealth. By integrating multiple sources of data together with the power of predictive analytics and machine learning, hospitals can create well-rounded solutions that address multiple issues or metrics.

4

Determine what you're looking for in a partner

As health systems continue along the journey of care innovation, there may be value in partnering with vendors or other providers to enable care delivery innovation. For example, there are vendors who have deep analytics capabilities, but don't have experience in implementing care delivery solutions. Understanding your needs enables you to determine the expertise that you would like to see in strategic partner. In the process, you may also want to consider the role of evidence generation and determine if the partner can support your goals.

5

Enable data transparency throughout your system

Increased transparency through quality reporting and other programs is motivating stakeholders to harness the power of data for collaboration. Even patients are looking at data when shopping for care. It's crucial that health system leaders are enabling appropriate data sharing to ensure that industry stakeholders can work together to solve major issues. While provider privacy and data safety are critical, providers must also determine how they can allow appropriate data sharing to enable care delivery innovation.

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PUBLISHER

Fawn Lopez	Vice President/ Publisher	312-649-5491	flopez@modernhealthcare.com

ADVERTISING

Ilana Klein	National Advertising Sales Director	312-649-5311	iklein@modernhealthcare.com
Jennifer McCullough	Project Manager	312-649-5353	jmccullough@modernhealthcare.com
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PRODUCTION

Michael Kanalas	Production Manager	312-280-3108	mkanalas@modernhealthcare.com

MARKETING

Katie Driscoll	Integrated Brand Development Director	312-649-7849	kdriscoll@modernhealthcare.com
Gianna Rizzi	Sales Marketing Coordinator	312-280-3163	grizzi@modernhealthcare.com

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AUDIENCE DEVELOPMENT

Mariah Craddick	Audience Engagement and Development Manager	312-649-5382	mcraddick@modernhealthcare.com
Lauren Melesio	Reprint sales	212-210-0707	lmelesio@modernhealthcare.com

EDUCATION AND EVENTS

Jodi Sniegocki	Education and Events Director	312-649-5459	jsniegocki@modernhealthcare.com
Steve Eck	Event Content Strategist	312-649-5346	seck@modernhealthcare.com
Adam Rubenfire	Custom Content Strategist	312-649-5229	arubenfire@modernhealthcare.com
Samantha Dillon	Senior Event Specialist	312-649-5340	sdillon@modernhealthcare.com
Sally Zimmerman	Content Coordinator	312-649-5499	szimmerman@modernhealthcare.com

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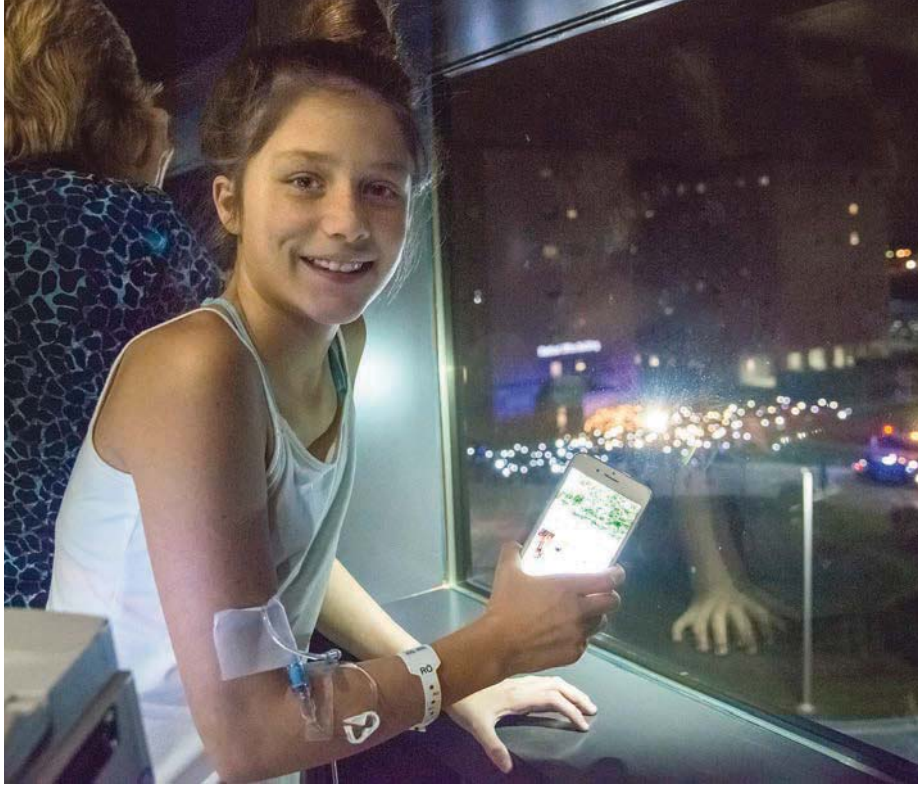
‘Moonbeams’ shine bright for young patients in Michigan



Kylie Bejin of Shelby Township, Mich., enjoys the “Moonbeams” display outside Beaumont Children’s hospital.

At 8 o’clock every night, the moonbeams, and the smiles, come out at Beaumont Children’s hospital in Royal Oak, Mich.

“Moonbeams for Sweet Dreams” was created by the Beaumont Children’s Pediatric Family Advisory Council. Every evening in December at bedtime in the pediatric unit, community members are invited to stand outside the hospital and shine flashlights up at the hospital windows, and pediatric patients shine lights back in a show of support and community.

The gesture is simple, and the display only lasts a few minutes, but the chorus of flashlights have brightened the lives of many on the pediatric ward.

“It’s a wonderful thing to look forward to—to realize that the community remembers these kids in the hospital,” said Tracey Huber whose 8-year-old son Mattias was recently hospitalized for an emergency appendectomy. “It was something my son and I could do together. And standing at the window, seeing all those people out there shining lights at us, I had tears in my eyes.”

The response from the community has been overwhelming. Participants have included members of local sports teams, Scouting troops and elementary school students, as well as families and neighbors. Multiple groups are currently signed up for each night in December on SignUpGenius, and some groups are as large as 100 people. However, you don’t need to sign up to attend; you just need a flashlight.

“The whole concept of light is so powerful this time of year,” Huber said. “It’s just an amazing way to connect with the community. There were times that I was positive that the people on the ground were following my flashlight. It’s an amazing connection.” ●

Feds tell Shkreli it’s time to face the music

Inmate No. 87850-053, aka Martin Shkreli, has been ordered to turn over his one-of-a-kind rap album as part of an asset forfeiture.

First he lost his freedom; now they’re coming for his music. Once Martin Shkreli was the smirking “Pharma Bro” who induced outrage by jacking up the price of a life-saving drug and insulting his detractors on social media.

Now he’s inmate No. 87850-053 at the Metropolitan Detention Center in Brooklyn, awaiting sentencing for his securities fraud conviction among terrorism and mob suspects.

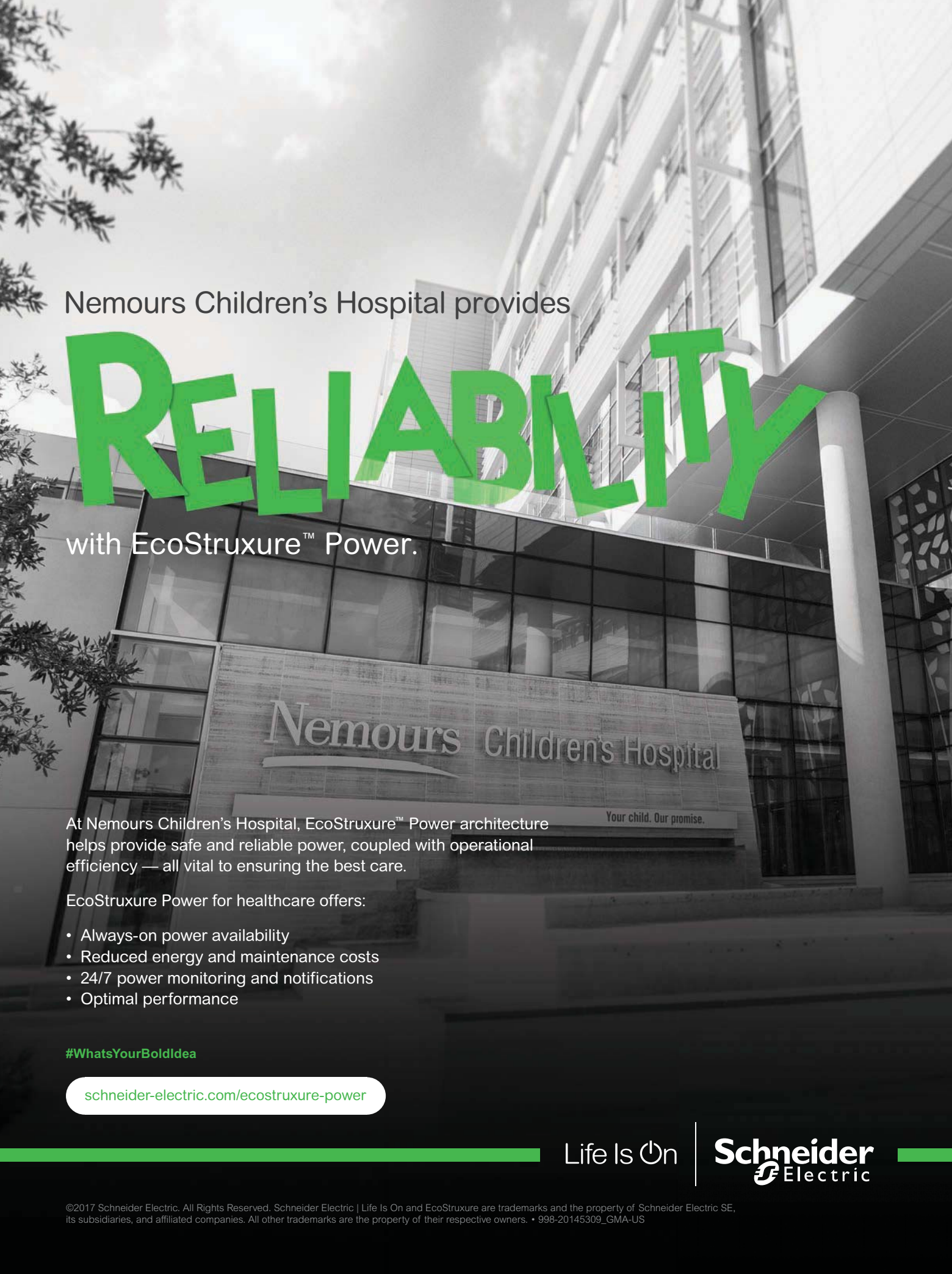
The feds now have their sights on his music—specifically the one-of-a-kind Wu-Tang Clan album Shkreli bought for $2 million in 2015.

According to the Associated Press, the recording is on a list of assets that prosecutors argue the former pharmaceutical CEO should forfeit after his conviction this year in a securities fraud scheme. In a letter filed in Brooklyn federal court, prosecutors told a judge that Shkreli, 34, is on the hook for $7.3 million.

Along with the Wu-Tang Clan “Once Upon a Time in Shaolin” album, prosecutors say Shkreli should give up $5 million in cash in a brokerage account, his interest in a pharmaceutical company and other valuables including a Picasso painting and another unreleased recording that he claims he owns, “Tha Carter V” by Lil Wayne.

Defense attorney Ben Brafman said Shkreli would fight the forfeiture.

A judge revoked Shkreli’s $5 million bail and threw him behind bars in September after he offered a $5,000 bounty on Facebook for a strand of Hillary Clinton’s hair. He’s due back in court for sentencing early next year, when the forfeiture demand will be decided. ●



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A supplement to Modern Healthcare | December 18, 2017

BY THE NUMBERS

2017-2018

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EDITORS
Aurora Aguilar Editor
312-649-5218 aaguilar@modernhealthcare.com

Matthew Weinstock Managing Editor
312-397-7585 mweinstock@modernhealthcare.com

Paul Barr Features Editor
312-649-5418 pbarr@modernhealthcare.com

Erica Teichert News Editor
212-210-0209 eteichert@modernhealthcare.com

David May Assistant Managing Editor
312-649-5451 dmay@modernhealthcare.com

Patricia Fanelli Art Director
312-649-5318 pfanelli@modernhealthcare.com

Keith Horist Production Manager
312-649-5467 khorist@modernhealthcare.com

Merrill Goozner Editor Emeritus
mgoozner@modernhealthcare.com

DIGITAL
Blair Chavis Web Producer
312-649-5225 bchavis@modernhealthcare.com

Emily Olsen Web Producer
312-649-5482 eolsen@modernhealthcare.com

Fan Fei Digital Graphics Producer
312-280-3155 ffei@modernhealthcare.com

SENIOR REPORTER
Harris Meyer Chicago
312-649-5343 hmeyer@modernhealthcare.com

REPORTERS
Rachel Z. Arndt Chicago
312-649-5314 rarndt@modernhealthcare.com

Tara Bannow Chicago
312-649-5362 tbannow@modernhealthcare.com

Maria Castellucci Chicago
312-397-5502 mcastellucci@modernhealthcare.com

Virgil Dickson Washington Bureau Chief
202-434-4552 vdickson@modernhealthcare.com

Steven Ross Johnson Chicago
312-649-5230 sjohnson@modernhealthcare.com

Alex Kacik Chicago
312-280-3149 akacik@modernhealthcare.com

Shelby Livingston Nashville
843-412-6857 slivingston@modernhealthcare.com

Susannah Luthi Washington
202-434-8462 sluthi@modernhealthcare.com

RESEARCH
Megan Caruso Research Associate
312-649-5471 mcaruso@modernhealthcare.com

COPY DESK
Julie A. Johnson Copy Desk Chief
312-649-5236 jajohnson@modernhealthcare.com

EDITORIAL SUPPORT
Valerie Lapointe News Intern
312-280-3173 vlapointe@modernhealthcare.com

CUSTOMER SERVICE
877-812-1581 customerservice@modernhealthcare.com

Modern Healthcare editorial offices at: 150 N. Michigan Ave., Chicago, Ill. 60601-7620; 685 Third Ave., New York, N.Y. 10017-4036; 104 East Park Drive, Building 300, Brentwood, Tenn. 37027; 1200 G St. NW, Suite 859, Washington, D.C. 20005; 1975 W. El Camino Real, Ste. 304, Mountain View, Calif. 94040Member of Business Publications Audit of Circulation.

Contents

Modern Healthcare's 19th annual By the Numbers supplement identifies the leading players across the industry, with a focus on hospitals and systems. Presented as lists, rankings and survey results, the data are intended to provide a snapshot of the healthcare landscape. But not all of the data fit in the issue—for longer lists and more snapshots visit **ModernHealthcare.com/Data**.

Also be on the lookout for some exciting new data offerings to be unveiled by Modern Healthcare in the new year as part of our joint venture with Healthcare Management Partners, Nashville. For a taste of what's to come, check out our list of the largest children's hospitals (p. 3) and the largest teaching hospitals (p. 4), which originated with Medicare data that was mined and cleansed by Healthcare Management Partners.

Comments and questions are welcome. Write the editor, Aurora Aguilar, at ModernHealthcare.com/Letters or directly at aaguilar@modernhealthcare.com. In addition, comment directly or publicly using either our Twitter handle, @modrnhealthcr, or on Facebook, facebook.com/modernhealthcare/.

Largest health systems

Sorted by operating revenue

RANK	SYSTEM	HEADQUARTERS	2016 OPERATING REVENUE ($ IN BILLIONS)	TAX STATUS
1	Kaiser Foundation Health Plan and Hospitals[1]	Oakland, Calif.	$64.55	Not-for-profit
2	HCA	Nashville	41.49	For-profit
3	Providence St. Joseph Health	Renton, Wash.	22.16	Not-for-profit
4	Ascension Health	St. Louis	21.90	Not-for-profit
5	Tenet Healthcare Corp.	Dallas	19.62	For-profit
6	Community Health Systems	Franklin, Tenn.	18.44	For-profit
7	Trinity Health	Livonia, Mich.	16.34	Not-for-profit
8	Catholic Health Initiatives[2]	Englewood, Colo.	15.19	Not-for-profit
9	UPMC	Pittsburgh	12.85	Not-for-profit
10	Dignity Health[2]	San Francisco	12.64	Not-for-profit
11	Partners Healthcare System	Boston	12.46	Not-for-profit
	Sutter Health	Sacramento, Calif.	11.87	Not-for-profit
12	Mayo Clinic Health System	Rochester, Minn.	11.00	Not-for-profit
	University of California Health System	Oakland, Calif.	10.42	Not-for-profit
13	Northwell Health	New Hyde Park, N.Y.	9.94	Not-for-profit
	Universal Health Services	King of Prussia, Pa.	9.77	For-profit
14	Adventist Health System	Altamonte Springs, Fla.	9.65	Not-for-profit
	New York City Health & Hospitals Corp.	New York	9.64	Not-for-profit
15	Baylor Scott & White Health	Dallas	8.37	Not-for-profit
	Cleveland Clinic Health System	Cleveland	8.04	Not-for-profit

[1] Integrated system, includes insurance premiums

[2] Agreed to merge.

Source: Modern Healthcare's 41st Annual Hospital Systems Survey

Information in this chart may be subsequently revised at the discretion of the editor.
For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.
FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

Largest for-profit hospital companies

Ranked by 2016 operating revenue

RANK	SYSTEM	TOTAL OPERATING REVENUE ($ IN MILLIONS) 2016	2015	OWNERSHIP
1	HCA	$41,490	$39,678	Publicly traded
2	Tenet Healthcare Corp.	19,621	18,634	Publicly traded
3	Community Health Systems	18,438	19,437	Publicly traded
4	Universal Health Services	9,766	9,044	Publicly traded
5	LifePoint Hospitals	6,364	5,214	Publicly traded
6	Prime Healthcare Services	4,445	3,724	Private
7	Iasis Healthcare Corp.*	3,253	2,769	Publicly traded
8	Steward Health Care*	2,280	2,180	Private
9	Quorum Health Corp.	2,138	2,187	Publicly traded

Note: Includes systems that are primarily focused on acute-care hospitals and those in which the numbers were available.

*Iasis and Steward merged in 2017.

Sources: U.S. Securities and Exchange Commission filings or the company, updated since it was originally published in the July 17 issue.

Largest children's hospitals

Ranked by total number of staffed beds, 2016

RANK	HOSPITAL	HEADQUARTERS	NUMBER OF STAFFED BEDS
1	Texas Children's Hospital, West Campus	Houston	681
2	Nationwide Children's Hospital	Columbus, Ohio	616
3	Cincinnati Children's Hospital Medical Center	Cincinnati	582
4	Children's Hospital of Philadelphia	Philadelphia	520
5	Phoenix Children's Hospital	Phoenix	433
6	Rady Children's Hospital and Health Center	San Diego	429
7	Children's Hospital Colorado	Aurora, Colo.	416
8	Boston Children's Hospital	Boston	415
9	Children's Hospital & Clinics of Minnesota	Minneapolis	413
10	Akron Children's Hospital	Akron, Ohio	391

Note: Bed count reflects total beds reported at the facility. Children's hospitals that do not have a CMS provider number and instead report through another entity were not considered in this ranking.

Source: Healthcare Management Partners analysis of CMS Healthcare Cost Report Information System (HCRIS), fiscal 2016.

Largest academic medical centers

Ranked by total number of residents, 2016

RANK	PROVIDER	LOCATION	NUMBER OF BEDS	NUMBER OF RESIDENTS
1	New York Presbyterian Hospital, Weill Cornell Medical Center	New York	2,408	1,559
2	Montefiore Hospital, Moses Campus	New York	1,524	1,196
3	NYU Langone Medical Center, Tisch Hospital	New York	1,044	1,005
4	University of Michigan, University Hospital	Ann Arbor	989	978
5	Johns Hopkins Hospital	Baltimore	993	915
6	Cleveland Clinic	Cleveland	1,285	909
7	Mount Sinai Hospital	New York	1,107	863
8	Yale New Haven Hospital	New Haven, Conn.	1,522	772
9	UPMC Presbyterian Shadyside	Pittsburgh	1,526	737
10	Barnes, Jewish Hospital South	St. Louis	1,323	716
11	LAC & USC Medical Center	Los Angeles	670	709
12	Jackson Memorial Hospital	Miami	1,750	699
	Hospital of University of Pennsylvania	Philadelphia	759	699
14	Indiana University Health	Indianapolis	1,287	678
15	University of Virginia Medical Center	Charlottesville	581	670
16	University of Rochester, Strong Memorial Hospital	Rochester, N.Y.	818	656
17	Ben Taub General Hospital	Houston	752	648
18	Ronald Reagan UCLA Medical Center	Los Angeles	456	647
19	Thomas Jefferson University Hospital	Philadelphia	889	645
20	University of North Carolina Medical Center	Chapel Hill	881	643

Note: Residents reported on a given hospital's cost report may have come from programs outside of an academic institution.

Source: Healthcare Management Partners analysis of CMS Healthcare Cost Report Information System (HCRIS), fiscal 2016.

Information in this chart may be subsequently revised at the discretion of the editor.
For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.
FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

10 largest healthcare systems, by hospital count

Ranked by total acute-care hospitals, 2016

RANK	SYSTEM	2016	2015
1	HCA	166	164
2	Ascension Health	111	112
3	Catholic Health Initiatives	103	102
4	LifePoint Health	67	63
5	Trinity Health	64	63
6	Providence St. Joseph Health	50	34
7	Sanford Health	42	41
8	Baylor Scott & White Health	40	37
9	Adventist Health System	34	35
10	Mercy Health (Chesterfield, Mo.)	29	30

Note: Includes only survey respondents.

Source: Modern Healthcare's 2017 Hospital Systems Survey, originally published in the July 17 issue

Largest health system-owned insurance operations

Ranked by covered lives

RANK	SYSTEM	COVERED LIVES
1	Kaiser Foundation Health Plan and Hospitals*	10,700,000
2	UPMC	3,022,270
3	Parkland Health & Hospital System	2,396,647
4	Intermountain Healthcare	852,000
5	Henry Ford Health System	658,074
6	Trinity Health	625,505
7	Geisinger Health System	551,518
8	Sentara Healthcare	445,533
9	Johns Hopkins Health System	343,612
10	Baylor Scott & White Health	256,211

**Membership numbers came from annual report for 2016*

Source: Modern Healthcare's 2017 Hospital Systems Survey

Executive compensation—healthcare systems

Ranked by average total cash compensation, 2017 ($ in thousands)

TITLE (NUMBER SURVEYED)	MEDIAN BASE 2017	MEDIAN BASE 2016	MEDIAN BASE CHANGE	MEDIAN TOTAL CASH COMPENSATION 2017	MEDIAN TOTAL CASH COMPENSATION 2016	MEDIAN TOTAL CASH COMPENSATION CHANGE	AVERAGE TOTAL CASH COMPENSATION 2017	AVERAGE TOTAL CASH COMPENSATION 2016	AVERAGE TOTAL CASH COMPENSATION CHANGE
TOP CORPORATE EXECUTIVES									
President and CEO (284)	$886.8	$856.9	3.5%	$1,120.4	$1,041.1	7.6%	$1,296.2	$1,236.3	4.8%
Chief operating officer (155)	576.8	550.0	4.9	701.3	645.0	8.7	801.0	750.0	6.8
Chief medical officer (187)	481.8	467.0	3.2	566.5	564.4	0.4	635.0	616.2	3.0
Chief financial officer (240)	512.7	491.5	4.3	619.1	593.2	4.4	689.0	659.6	4.5
Chief administrative officer (46)	514.1	478.1	7.5	612.2	593.6	3.1	695.7	652.6	6.6
Chief strategy officer (81)	432.2	405.9	6.5	548.9	482.1	13.9	602.6	562.6	7.1
Chief information officer (187)	385.8	371.3	3.9	440.7	424.4	3.9	481.8	454.2	6.1
Compliance executive (112)	252.5	244.6	3.2	291.1	266.7	9.2	297.5	282.2	5.4
Chief nursing officer/patient care executive (174)	314.7	305.0	3.2	363.1	348.1	4.3	382.4	365.7	4.6
Chief technology officer (33)	245.9	236.4	4.0	287.1	291.3	-1.4	307.6	301.5	2.0

Source: Sullivan, Cotter and Associates, originally published in the Aug. 14 issue.

Largest master's programs in health administration

Ranked by total full-time enrollment in 2016-17 academic year

RANK	INSTITUTION	LOCATION	SCHOOL OR DEPARTMENT	PRIMARY DEGREE	NUMBER OF FULL-TIME STUDENTS
1	University of Scranton	Scranton, Pa.	College of Professional Studies	MHA	153
2	Seton Hall University	South Orange, N.J.	School of Health and Medical Sciences	MHA	110
3	University of Missouri	Columbia	Department of health management and informatics	MHA	98
4	University of Alabama at Birmingham	Birmingham	School of Health Professionals	MSHA	96
5	Columbia University	New York	Mailman School of Public Health and department of health policy management	MHA	94
6	California State University at Long Beach	Long Beach, Calif.	Department of healthcare administration	MS	89
7	Texas Woman's University	Houston, Texas	School of Management	MHA	82
8	Army-Baylor University	Fort Sam Houston, Texas	Graduate School, Health and Business Administration	MHA	81
9	University of Iowa	Iowa City	College of Public Health	MHA	73
10	Xavier University	Cincinnati	College of Professional Sciences	MHSA	66

Note: Information is self-reported from colleges and universities responding to Modern Healthcare's survey. Only those that participated were considered for this ranking and only those with Commission on Accreditation of Healthcare Management Education accreditation are included.
Degree abbreviations: MHA=Master of Health Administration; MHSA=Master of Health Science Administration; MPA=Master of Public Administration; MPH=Master of Public Health; MSHA=Master of Science in Health Administration; MS=Master of Science

Source: Modern Healthcare's 2017 Master's Programs in Health Administration Survey, updated since it was originally published in the March 27 issue.

Executive compensation—hospitals

Selected titles, ranked by average total cash compensation, 2017 ($ in thousands)

	MEDIAN						AVERAGE		
	BASE			TOTAL CASH COMPENSATION			TOTAL CASH COMPENSATION		
TITLE (NUMBER SURVEYED)	2017	2016	CHANGE	2017	2016	CHANGE	2017	2016	CHANGE
C-SUITE EXECUTIVES									
President and CEO, stand-alone hospital (61)	$550.0	$530.0	3.8%	$648.7	$658.0	(1.4%)	$716.3	$696.2	2.9%
President and CEO, system-owned hospital (371)	384.6	371.4	3.6	468.8	447.2	4.8	497.0	484.5	2.6
Chief operating officer, stand-alone hospital (31)	360.0	376.7	(4.4)	411.3	410.8	0.1	440.3	435.9	1.0
Chief operating officer, system-owned hospital (151)	277.1	274.2	1.1	324.4	317.6	2.2	347.3	337.7	2.9
Chief medical officer, stand-alone hospital (31)	361.7	349.6	3.4	399.6	390.4	2.4	426.0	417.3	2.1
Chief medical officer, system-owned hospital (140)	356.9	348.2	2.5	408.0	399.2	2.2	425.1	414.6	2.6
Chief financial officer, stand-alone hospital (54)	343.9	325.8	5.6	380.2	363.4	4.6	395.5	384.6	2.8
Chief financial officer, system-owned hospital (145)	266.8	255.7	4.4	306.5	289.8	5.8	313.6	302.5	3.7
Chief information officer (37)	273.0	262.7	3.9	297.4	291.3	2.1	303.2	297.8	1.8
Chief nursing officer/patient care executive (532)	206.0	200.2	2.9	238.3	238.1	0.1	247.0	244.5	1.0

Source: Sullivan, Cotter and Associates, originally published in the Aug. 14 issue.

Largest healthcare executive search firms

Ranked by total number of U.S. placements made for senior-level healthcare executives* in 2016

RANK/COMPANY	HEADQUARTERS	TYPE	NET REVENUE ($ IN MILLIONS)[1]	2016 RECRUITERS[2]	2016 PLACEMENTS
1 B.E. Smith	Lenexa, Kan.	Retained	$94.0	42	515
2 Korn Ferry	Los Angeles	Retained	188.0	43	456
3 Reaction Search International	San Ramon, Calif.	Retained	–	36	365
4 Witt/Kieffer	Oak Brook, Ill.	Retained	47.9	104	330
5 Solomon Page Group Healthcare	New York	Retained	9.7	27	280
6 Merraine Group	Stuart, Fla.	Retained and contingent	—	39	279
7 Diversified Search	Philadelphia	Retained	15.3	32	245
8 Grant Cooper	St. Louis	Retained	—	20	213
9 Cejka Search	St. Louis	Retained	—	43	202
10 Furst Group	Rockford, Ill.	Retained	—	21	195

Note: Data are self-reported from companies that chose to participate in Modern Healthcare's survey. Only those that had 20 or more placements were considered for the rankings. B.E. Smith, Korn Ferry and Cejka Search are publicly traded companies; all others listed are privately held.

*Senior vice president and above

[1]From healthcare-related fees only

[2]Number of recruiters employed in 2016 who spent at least 50% of their time on healthcare placements

Source: Modern Healthcare's 2017 Executive Search Firms Survey, originally publishe in the Aug. 14 issue

Largest healthcare management consulting firms

Ranked by 2016 total healthcare revenue

RANK	COMPANY	HEADQUARTERS	TOTAL PROVIDER CONTRACTS 2016	TOTAL HEALTHCARE CONTRACTS 2016	TOTAL PROVIDER REVENUE 2016 ($ MILLIONS)	TOTAL HEALTHCARE REVENUE 2016 ($ MILLIONS)
1	Deloitte Consulting	New York	4,350	12,900	$981.18	$2,642.46
2	KPMG	New York	2,450	3,200	437.00	843.80
3	Advisory Board Co.	Washington, D.C.	3,500	4,600	803.40	803.40
4	Navigant Consulting	Chicago	–	–	389.10	432.60
5	Vizient	Irving, Texas	756	785	301.10	303.70
6	FTI Consulting	Washington, D.C.	1,769	1,769	269.82	269.82
7	Berkeley Research Group	Emeryville, Calif.	205	269	125.00	190.00
8	Alvarez & Marsal Healthcare Industry Group	New York	–	–	137.47	149.98
9	Crowe Horwath	Chicago	1,538	1,538	128.83	128.83
10	ECG Management Consultants	Seattle	1,735	1,735	92.18	92.18

Note: Information is self-reported from companies responding to Modern Healthcare's 2017 Healthcare Management Consulting Firms Survey.

Accenture, Ernst & Young, Huron Healthcare, McKinsey & Co., Oliver Wyman and PricewaterhouseCoopers did not participate in the 2017 survey.

Healthcare IT firms are omitted from the above ranking. Revenue figures in millions, rounded.

Total healthcare revenue and total healthcare contracts represent consulting work with providers as well as other sectors of the healthcare industry.

Source: Modern Healthcare's 2017 Healthcare Management Consulting Firms Survey, originally published in the Aug. 28 issue.

Largest U.S. per diem nurse staffing firms

Ranked by estimated 2015 U.S. temporary staffing revenue

RANK	COMPANY	HEADQUARTERS	2015 U.S. PER DIEM NURSE TEMPORARY STAFFING REVENUE ($ IN MILLIONS)	MARKET SHARE
1	Maxim Healthcare Services	Columbia, Md.	$238	7.7%
2	Cross Country Healthcare[1]	Boca Raton, Fla.	218	7.0
3	HealthTrust Workforce Solutions (HCA)[2]	Sunrise, Fla.	162	5.2
4	Supplemental Health Care	Chicago	90	2.9
5	AMN Healthcare Services[3]	San Diego	82	2.6

[1]Includes revenue from Mediscan, acquired 4Q 2015.

[2]Formerly known as Parallon Workforce Solutions prior to 3Q 2016.

[3]Includes revenue from Onward Healthcare, acquired in 1Q 2015.

Source: Staffing Industry Analysts, originally published in the Jan 16 issue.

For more information on the data used to compile this chart, contact Staffing Industry Analysts, 1975 W. El Camino Real, Suite 304, Mountain View, CA 94040; 800-950-9496; staffingindustry.com

Information in this chart subsequently may be revised at the discretion of the editor.

For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.

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Biggest spenders in healthcare lobbying

Ranked by 2017 lobbying expenditures as of October

RANK	ORGANIZATION	LOCATION	REPORTED TOTAL
1	American Medical Association	Chicago	$16,970,000
2	Blue Cross and Blue Shield Association	Chicago	16,531,960
3	American Hospital Association	Chicago	12,910,000
4	America's Health Insurance Plans	Washington, D.C.	4,820,000
5	Federation of American Hospitals	Washington, D.C.	3,030,000
	National Association of Children's Hospitals	Washington, D.C.	3,030,000
7	Association of American Medical Colleges	Washington, D.C.	2,789,000
8	American Academy of Family Physicians	Leawood, Kan.	2,156,967
9	American Health Care Association	Washington, D.C.	1,740,000
10	Kindred Healthcare	Louisville, Ky.	1,700,000
11	Select Medical Holdings	Mechanicsburg, Pa.	1,630,000
12	Greater New York Hospital Association	New York	1,600,000
13	American Congress of Obstetricians and Gynecologists	Washington, D.C.	1,538,465
14	American College of Cardiology	Glenview, Ill.	1,510,000
15	American College of Emergency Physicians	Irving, Texas	1,507,327
16	American Academy of Dermatology Association	Schaumburg, Ill.	1,370,000
17	American College of Radiology	Reston, Va.	1,251,394
18	Tenet Healthcare Corp.	Dallas	1,160,000
19	UPMC Health System	Pittsburgh	995,000
20	Ascension Health	St. Louis	968,000

Note: All lobbying expenditures come from the Senate Office of Public Records. Numbers reported are accurate as of Oct. 21, 2017.

Sources: OpenSecrets.org and the Center for Responsive Politics

Information in this chart may be subsequently revised at the discretion of the editor.
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Largest post-acute care companies

Ranked by net revenue for the organization's fiscal 2016

RANK	COMPANY	OWNERSHIP	TYPE	FISCAL YEAR-END	NET REVENUE ($ IN MILLIONS) 2016	NET REVENUE ($ IN MILLIONS) 2015	NET INCOME ($ IN MILLIONS) 2016	NET INCOME ($ IN MILLIONS) 2015	TOTAL FACILITIES 2016*	TOTAL STATES 2016
1	Kindred Healthcare	Public	LTAC	Dec. 31	$7,219.5	$7,054.9	($664.2)	($93.4)	188	46
2	Genesis HealthCare	Public	SNF	Dec. 31	5,732.4	5,619.2	0.0	0.0	499	34
3	Brookdale Senior Living	Public	SNF	Dec. 31	4,977.0	4,960.6	(404.4)	(457.5)	1,055	46
4	Select Medical	Public	LTAC	Dec. 31	4,286.0	3,742.7	115.4	130.7	2,034	46
5	HealthSouth Corp.[1]	Public	Rehab	Dec. 31	3,707.2	3,162.9	247.6	183.1	346	35
6	Ensign Group[2]	Public	SNF	Dec. 31	1,654.9	1,341.8	52.8	55.9	210	9
7	Amedisys	Public	Home H	Dec. 31	1,437.5	1,280.5	37.3	3.0	411	35
8	Five Star Quality Care[2]	Public	Assisted	Dec. 31	1,378.1	1,365.4	21.8	43.1	283	32
9	Vitas Healthcare[2,3]	Public	Hospice	Dec. 31	1,123.3	1,115.6	85	93.3	187	19
10	National HealthCare Corp.[2]	Public	SNF	Dec. 31	926.6	906.6	50.5	53.1	100	10
11	LHC Group	Public	Home H	Dec. 31	914.8	816.4	36.6	32.3	376	28
12	Vibra Healthcare	Private	LTAC	Dec. 31	818.1	779.3	0.0	0.0	43	17
13	UPMC Community Provider Services	NFP	Home H	June 30	730.0	505.7	55.5	29.5	107	1
14	Athena Health Care Systems	Private	SNF	Sept. 30	595.4	571.1	21.0	13.1	49	3
15	Covenant Care	Private	SNF	Dec. 31	561.8	569.5	0.0	0.0	55	7
16	Capital Senior Living[2]	Public	Assisted	Dec. 31	447.4	412.2	(28.0)	(14.3)	129	23
17	Diversicare Healthcare Services	Public	SNF	Dec. 31	426.1	387.6	(1.8)	1.6	76	10
18	New Jewish Home	NFP	SNF	Dec. 31	255.1	283.2	46.4	(2.7)	2	1
19	Nexion Health	Private	SNF	Dec. 31	252.2	247.5	(3.4)	0.1	38	3
20	Benedictine Health System	NFP	SNF	June 30	249.5	237.0	(6.0)	(2.3)	42	5

Companies included in this listing have a primary business in long-term or post-acute care and own/operate two or more service locations. Ownership: not-for-profit (NFP); publicly traded for-profit (Public); privately held for-profit (Private). Type refers to the company's main business: Assisted-living facilities (Assisted); home health (Home H); long-term acute-care hospitals (LTAC); rehabilitation hospitals (Rehab); and skilled-nursing facilities (SNF).

*Total facilities include all operations of the company.

[1]Information submitted includes data from Encompass Home Health & Hospice. [2]Information taken from Securities and Exchange Commission filings. [3]Owned by Chemed Corp.

Sources: Modern Healthcare's 2017 Post-Acute-Care Survey; Securities and Exchange Commission filings, originally published in the Oct. 23 issue.

Information in this chart may be subsequently revised at the discretion of the editor.

For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.

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**Home Health Compare Star Ratings released by the Centers for Medicare & Medicaid Services for the reporting period of October 2017.*

Largest healthcare law firms

Ranked by number of healthcare lawyers employed in 2016

RANK	FIRM	LOCATION	NUMBER OF HEALTHCARE LAWYERS IN 2016
1	Morgan, Lewis & Bockius	Washington, D.C.	293
2	Hall, Render, Killian, Heath & Lyman	Indianapolis	206
3	Baker Donelson	Nashville	196
4	Reed Smith	Washington, D.C.	192
5	Jones Day	Cleveland	186
6	Bass, Berry & Sims	Nashville	184
7	Waller Lansden Dortch & Davis	Nashville	183
8	Polsinelli	Kansas City, Mo.	173
9	Sheppard Mullin Richter & Hampton	Los Angeles	165
10	Epstein Becker & Green	New York	162
11	McGuireWoods	Richmond, Va.	147
12	Norton Rose Fulbright	Houston	146
13	Mintz, Levin, Cohn, Ferris, Glovsky and Popeo	Boston	145
14	Dentons	New York	141
15	Faegre Baker Daniels	Minneapolis	140
16	Bradley Arant Boult Cummings	Nashville	134
17	Drinker Biddle & Reath	Philadelphia	121
18	Alston & Bird	Atlanta	120
	Greenberg Traurig	New York	120
20	Pepper Hamilton	Philadelphia	116
21	DLA Piper	New York	115
22	Husch Blackwell	Kansas City, Mo.	111
23	King & Spalding	Atlanta	104
24	Squire Patton Boggs	Washington, D.C.	88
25	Butler Snow	Ridgeland, Miss.	84
26	Proskauer Rose	New York	82
27	Akin Gump Strauss Hauer & Feld	Washington, D.C.	78
28	Locke Lord	Dallas	76
29	Baker & Hostetler	Cleveland	75
30	Manatt, Phelps & Phillips	Los Angeles	64
31	Hooper, Lundy & Bookman	Los Angeles	60
32	Bricker & Eckler	Columbus, Ohio	47
33	Fox Rothschild	Philadelphia	45
34	Dickinson Wright	Detroit	42
35	Arnall Golden Gregory	Atlanta	38
	Crowell & Moring	Washington, D.C.	38
37	Arent Fox	Washington, D.C.	35
38	Seyfarth Shaw	Chicago	26
	LeClairRyan	Richmond, Va.	26
	Littler Mendelson	San Francisco	26
41	Nelson Hardiman	Los Angeles	20
42	Benesch	Cleveland	17
43	Krieg DeVault	Indianapolis	14
	Vorys, Sater, Seymour and Pease	Columbus, Ohio	14
45	Breazeale, Sachse & Wilson	Baton Rouge, La.	12
46	Von Briesen & Roper	Milwaukee	10
47	Baird Holm	Omaha, Neb.	9
48	Conner & Winters	Tulsa, Okla.	8
	Lewis Roca Rothgerber Christie	Phoenix	8
50	Florida Healthcare Law Firm	Delray Beach	7

Source: Modern Healthcare's 2017 Law Firms Survey, originally published in the June 26/July 3 issue.

Information in this chart subsequently may be revised at the discretion of the editor.

For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.

FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

Largest U.S. healthcare public relations/marketing agencies

Ranked by 2016 U.S. revenue ($ in millions)

RANK	AGENCY (PARENT COMPANY)	HEADQUARTERS	2016 U.S. REVENUE
1	Omnicom Health Group* [1] (Omnicom)	New York	$808.5
2	Publicis Health* (Publicis)	New York	770.0
3	inVentiv Health Communications* [2]	New York	335.0
4	FCB Health* (Interpublic Group of Cos.)	New York	258.3
5	Havas Health & You* (Havas)	New York	219.0
6	PwC Digital Services (PwC)	New York	210.0
7	McCann Health/McCann HumanCare* (Interpublic Group of Cos.)	New York	174.9
8	Wunderman Health* (WPP)	New York	174.2
9	Klick Health	Toronto	145.2
10	Rapp* (Omnicom)	New York	140.4

Data gathered by Ad Age Datacenter (Agency Report 2017). Company name in parentheses shows affiliation with a major agency company. 2016 revenue and ranking are based on data collected and/or adjusted in 2017. Revenue figures are pro forma and rounded.

*Indicates Ad Age Datacenter estimate.

[1]Omnicom operates some healthcare agencies outside of Omnicom Health Group.

[2]Estimated revenue for inVentiv Health's advertising, public relations, medical communications and data analytics.

Source: Ad Age, a Crain Communications sister publication, originally published in the Nov. 6 issue.

Physician compensation survey

Key:
AMGA
Cejka Search
Compdata Surveys & Consulting
ECG Management Consultants[1]
Jackson Physician Search
The Medicus Firm[1]
Merritt Hawkins[2]
Medical Group Management Association
Pacific Companies[1]
Pinnacle Health Group[1]
Sullivan, Cotter & Associates medical groups (M)
Sullivan, Cotter & Associates[1] physicians (P)

ANESTHESIOLOGY

Compensation range: $354,357 to $447,796		% change 2015-16
MGMA	$447,796	(1.95%)
Sullivan-M	$428,888	(0.10%)
AMGA	$415,685	(0.21%)
ECG	$408,444	9.10%
Pacific	$406,000	(1.22%)
Sullivan-P	$403,549	0.58%
Jackson	$402,000	NA
Medicus	$401,000	3.08%
Merritt	$376,000	(5.29%)
Compdata	$368,700	3.05%
Pinnacle	$354,357	1.7%
Cejka	NA	NA

CARDIOLOGY (INVASIVE)

Compensation range: $431,804 to $673,900		% change 2015-16
Compdata	$673,900	12.62%
Sullivan-M	$614,714	2.85%
Sullivan-P	$605,844	2.85%
AMGA	$598,675	2.49%
MGMA	$588,638	3.88%
Merritt	$563,000	3.30%
Pacific	$554,000	2.40%
ECG	$541,072	8.80%
Medicus	$454,000	(4.62%)
Pinnacle	$431,804	(14.28%)
Cejka	NA	NA
Jackson	NA	NA

CARDIOLOGY (NON-INVASIVE)

Compensation range: $391,624 to $489,459		% change 2015-16
Sullivan-M	$489,459	5.78%
AMGA	$485,945	0.47%
MGMA	$470,610	3.99%
Sullivan-P	$462,550	4.64%
Pacific	$461,000	4.30%
ECG	$449,607	9.30%
Jackson	$436,000	NA
Merritt	$428,000	(13.18%)
Compdata	$424,000	(12.32%)
Pinnacle	$391,624	(6.28%)
Cejka	NA	NA
Medicus	NA	NA

GENERAL SURGERY

Compensation range: $312,889 to $441,262		% change 2015-16
Sullivan-M	$441,262	4.01%
Sullivan-P	$414,609	3.21%
AMGA	$413,047	(0.19%)
Merritt	$411,000	8.73%
MGMA	$407,519	(0.52%)
ECG	$404,081	6.37%
Pacific	$398,000	3.11%
Medicus	$379,000	2.16%
Compdata	$375,400	3.50%
Jackson	$367,000	NA
Cejka	$350,455	6.47%
Pinnacle	$312,889	(3.70%)

HOSPITALIST

Compensation range: $238,000 to $292,687		% change 2015-16
Sullivan-M	$292,687	5.57%
MGMA	$285,102	2.28%
Sullivan-P	$284,495	7.62%
AMGA	$281,500	2.23%
Pacific	$272,000	1.12%
ECG	$269,472	5.07%
Medicus	$266,000	2.31%
Merritt	$264,000	6.02%
Cejka	$258,429	24.02%
Pinnacle	$257,348	3.74%
Compdata	$244,200	9.21%
Jackson	$238,000	NA

INTENSIVIST

Compensation range: $273,400 to $400,232		% change 2015-16
Sullivan-M	$400,232	2.17%
AMGA	$400,000	0.08%
ECG	$399,791	8.40%
Pacific	$391,000	6.54%
Sullivan-P	$386,420	3.05%
MGMA	$381,000	(4.31%)
Merritt	$380,000	8.57%
Pinnacle	$303,771	(4.82%)
Compdata	$273,400	1.79%
Cejka	NA	NA
Jackson	NA	NA
Medicus	NA	NA

INTERNAL MEDICINE

Compensation range: $211,364 to $275,752		% change 2015-16
Sullivan-M	$275,752	4.15%
Sullivan-P	$262,640	3.29%
AMGA	$259,765	4.08%
Merritt	$257,000	8.44%
Medicus	$255,000	(1.16%)
ECG	$252,750	5.15%
Compdata	$251,000	1.13%
MGMA	$247,954	0.26%
Pacific	$246,000	1.65%
Jackson	$237,000	NA
Pinnacle	$233,034	3.35%
Cejka	$211,364	(6.93%)

ORTHOPEDIC SURGERY

Compensation range: $465,556 to $621,113		% change 2015-16
Sullivan-M	$621,113	5.92%
MGMA	$592,019	2.66%
Sullivan-P	$591,322	5.45%
AMGA	$581,092	(0.17%)
Medicus	$581,000	4.68%
Merritt	$579,000	11.13%
Pacific	$579,000	2.84%
ECG	$574,910	5.63%
Compdata	$534,700	4.70%
Jackson	$526,000	NA
Pinnacle	$468,772	7.76%
Cejka	$465,556	5.41%

PATHOLOGY

Compensation range: $253,100 to $375,473		% change 2015-16
Sullivan-M	$375,473	5.60%
AMGA	$373,794	2.79%
ECG	$363,003	7.70%
MGMA	$354,814	3.58%
Sullivan-P	$343,048	6.54%
Pinnacle	$326,301	54.65%
Merritt	$290,000	6.62%
Compdata	$253,100	(8.06%)
Cejka	NA	NA
Jackson	NA	NA
Medicus	NA	NA
Pacific	NA	NA

PEDIATRICS

Compensation range: $183,600 to $259,862		% change 2015-16
Sullivan-M	$259,862	0.67%
Sullivan-P	$244,178	0%
ECG	$242,084	9.90%
AMGA	$241,116	2.49%
Merritt	$240,000	7.14%
Medicus	$229,000	2.69%
MGMA	$228,068	(1.49%)
Pacific	$227,000	1.34%
Compdata	$215,000	(2.80%)
Jackson	$207,670	NA
Cejka	$202,500	(2.41%)
Pinnacle	$183,600	(13.7%)

PLASTIC SURGERY

Compensation range: $335,117 to $550,840		% change 2015-16
Sullivan-M	$550,840	3.10%
AMGA	$528,283	3.58%
Sullivan-P	$510,909	0.51%
MGMA	$509,561	2.68%
ECG	$493,445	7.80%
Pacific	$398,000	(1.00%)
Compdata	$380,900	14.49%
Merritt	$350,000	2.34%
Pinnacle	$335,117	0.03%
Cejka	NA	NA
Jackson	NA	NA
Medicus	NA	NA

Note: Figures represent average total annual cash compensation, which includes salary and bonuses. Percentages rounded.
[1]Company provided preliminary data. [2]Company data tracks average starting salaries for physicians, rather than average incomes.

DERMATOLOGY

Compensation range: $203,396 to $504,746		% change 2015-16
ECG	$504,746	8.90%
Sullivan-M	$503,510	3.11%
Pacific	$469,000	1.52%
Sullivan-P	$467,487	2.87%
AMGA	$457,118	5.20%
Compdata	$437,700	(11.34%)
MGMA	$422,884	(7.55%)
Merritt	$421,000	(5.18%)
Jackson	$403,000	NA
Cejka	$300,000	0%
Pinnacle	$203,396	(35.51%)
Medicus	NA	NA

EMERGENCY MEDICINE

Compensation range: $279,440 to $372,365		% change 2015-16
Pinnacle	$372,365	21.35%
Sullivan-M	$353,985	2.90%
Merritt	$349,000	14.80%
AMGA	$348,178	(2.00%)
Pacific	$340,000	0.89%
Sullivan-P	$338,058	6.78%
Compdata	$337,100	8.43%
Medicus	$337,000	14.24%
MGMA	$334,065	7.12%
Jackson	$323,000	NA
ECG	$318,277	5.33%
Cejka	$279,440	6.10%

FAMILY PRACTICE

Compensation range: $210,614 to $264,123		% change 2015-16
Sullivan-M	$264,123	6.40%
Sullivan-P	$255,534	5.69%
AMGA	$242,210	3.20%
ECG	$242,000	4.73%
MGMA	$234,110	1.87%
Pacific	$233,000	1.75%
Merritt	$231,000	2.67%
Medicus	$229,000	1.33%
Compdata	$228,500	0.93%
Jackson	$223,250	NA
Cejka	$210,667	(1.10%)
Pinnacle	$210,614	(2.83%)

GASTROENTEROLOGY

Compensation range: $394,023 to $531,696		% change 2015-16
MGMA	$531,696	0.47%
Pacific	$527,000	1.54%
Sullivan-M	$526,685	3.44%
AMGA	$519,124	2.76%
ECG	$505,582	2.67%
Cejka	$497,433	16.36%
Sullivan-P	$493,194	3.35%
Merritt	$492,000	7.42%
Medicus	$443,000	(1.34%)
Compdata	$424,800	(0.47%)
Jackson	$419,333	NA
Pinnacle	$394,023	(7.51%)

NEONATOLOGY

Compensation range: $245,000 to $356,000		% change 2015-16
Pacific	$356,000	2.30%
Sullivan-M	$348,763	7.77%
AMGA	$337,388	10.69%
Merritt	$336,000	7.69%
MGMA	$322,758	(0.17%)
Compdata	$315,300	9.29%
Sullivan-P	$314,354	4.27%
ECG	$305,478	7.26%
Pinnacle	$245,000	10.73%
Cejka	NA	NA
Jackson	NA	NA
Medicus	NA	NA

NEUROLOGY

Compensation range: $249,786 to $314,500		% change 2015-16
Compdata	$314,500	7.26%
Sullivan-M	$307,584	4.79%
MGMA	$305,989	6.99%
Merritt	$305,000	7.02%
AMGA	$295,211	3.67%
ECG	$291,861	5.77%
Sullivan-P	$291,247	5.24%
Medicus	$287,000	0.70%
Pacific	$286,000	5.54%
Cejka	$278,046	12.34%
Jackson	$268,000	NA
Pinnacle	$249,786	(13.32%)

OBSTETRICS-GYNECOLOGY

Compensation range: $257,667 to $371,803		% change 2015-16
Sullivan-M	$371,803	5.30%
Sullivan-P	$351,222	5.53%
AMGA	$342,700	2.84%
MGMA	$340,691	3.02%
ECG	$337,050	5.57%
Merritt	$335,000	4.36%
Pacific	$334,000	3.09%
Compdata	$330,400	4.66%
Medicus	$320,000	7.74%
Jackson	$301,333	NA
Pinnacle	$274,670	(15.75%)
Cejka	$257,667	(1.1%)

ONCOLOGY (INCL. HEMATOLOGY)

Compensation range: $320,265 to $493,900		% change 2015-16
Compdata	$493,900	4.02%
Merritt	$471,000	7.78%
Sullivan-M	$451,890	4.39%
MGMA	$448,000	1.01%
AMGA	$444,766	6.73%
Pacific	$434,000	1.64%
ECG	$427,344	9.83%
Medicus	$425,000	3.91%
Sullivan-P	$408,923	7.00%
Cejka	$342,500	(10.71%)
Jackson	$336,330	NA
Pinnacle	$320,265	(18.18%)

PSYCHIATRY

Compensation range: $223,400 to $272,374		% change 2015-16
Sullivan-M	$272,374	4.31%
MGMA	$267,766	4.78%
AMGA	$266,540	4.55%
Merritt	$263,000	5.20%
Pacific	$262,000	1.16%
ECG	$256,636	4.20%
Sullivan-P	$252,976	5.61%
Medicus	$248,000	4.20%
Jackson	$245,250	NA
Compdata	$239,700	(2.80%)
Pinnacle	$235,182	0.70%
Cejka	$223,400	7.66%

RADIATION ONCOLOGY

Compensation range: $350,000 to $544,400		% change 2015-16
Compdata	$544,400	4.95%
Sullivan-M	$541,123	3.16%
AMGA	$525,000	0.86%
MGMA	$523,121	4.62%
Sullivan-P	$515,999	7.46%
ECG	$502,996	0.80%
Merritt	$488,000	8.44%
Pacific	$485,000	(1.22%)
Pinnacle	$350,000	(3.23%)
Cejka	NA	NA
Jackson	NA	NA
Medicus	NA	NA

RADIOLOGY

Compensation range: $313,628 $529,244		% change 2015-16
ECG	$529,244	7.41%
Sullivan-M	$515,670	0.46%
AMGA	$503,225	2.62%
MGMA	$489,090	0.61%
Sullivan-P	$478,788	1.28%
Pacific	$476,000	(1.45%)
Medicus	$470,000	9.05%
Merritt	$436,000	(8.21%)
Compdata	$429,600	3.47%
Jackson	$386,000	NA
Pinnacle	$313,628	(1.02%)
Cejka	NA	NA

UROLOGY

Compensation range: $341,358 to $476,191		% change 2015-16
Sullivan-M	$476,191	2.87%
ECG	$469,514	8.91%
Pacific	$462,000	(0.65%)
Merritt	$460,000	(2.34%)
AMGA	$453,680	2.68%
Sullivan-P	$452,232	2.91%
MGMA	$447,916	(0.97%)
Medicus	$442,000	3.03%
Jackson	$425,000	NA
Compdata	$390,500	4.30%
Pinnacle	$341,358	(9.73%)
Cejka	NA	NA

Source: Modern Healthcare's 2017 Physician Compensation Survey, originally published in the July 24 issue.

Largest business graduate schools for physician-executives

Ranked by number of graduates from the program at the end of the 2016-17 school year

RANK	INSTITUTION	DEGREES OFFERED	FULL-TIME STUDENTS	PART-TIME STUDENTS	TUITION	LENGTH OF PROGRAM (MONTHS)	TOTAL GRADUATES, 2016-17
1	Temple University, Fox School of Business	MBA, EMBA	89	847	$31,293	18	265
2	Michigan State University[1]	EMBA	0	224	72,000	20	133
3	Florida International University, Chapman Graduate School of Business[2]	MBA	0	202	52,000	18	116
4	Columbia University, Mailman School of Public Health	MHA, MPH	100	135	36,420	23	110
5	University of Massachusetts at Amherst, Isenberg School of Management[2]	MBA	0	287	29,000	32	94
6	Duke University, Fuqua School of Business[1,2]	MBA	96	0	122,500	19	92
7	George Washington University	MBA	52	95	25,350	42	66
8	Clarkson University, Capital Region Campus	MBA, MS	28	26	28,000	24	36
9	Johns Hopkins University, Bloomberg School of Public Health	MHA, DrPH, MASPHM	56	87	56,000	24	35
	University of Tennessee[2]	MBA	77	0	76,000	12	35
11	University of North Carolina at Chapel Hill[2]	MHA, MPH	65	5	17,000	24	32
12	Emory University[1,2]	EMBA	0	178	101,700	19.5	31
13	Carnegie Mellon University[2]	MMM	58	0	19,570	18	30
14	University of Miami, School of Business Administration	EMBA/ HSMP	53	0	47,320	23	28
15	Auburn University[2]	MBA	63	0	34,965	21	27

Note: Information is self-reported from institutions responding to Modern Healthcare's annual survey; only those that participated were included in this ranking.

[1]Tuition represents two-year cost.

[2]Tuition includes any or all of the following: textbooks, materials, tablets or PCs, meals, lodging, seminars.

EMBA–Executive Master of Business Administration; EMBA/HSMP–Executive Master of Business Administration in Health Sector Management and Policy; DrPH–Doctor of Public Health; MHA–Master of Health Administration; MPH–Master of Public Health; MMM–Master of Medical Management; MS–Master of Science; MASPHM–Master of Applied Science Population Health Management.

Source: Modern Healthcare's 2017 Business Graduate Schools for Physician-Executives Survey, originally published in the Oct. 9 issue.

Information in this chart may be subsequently revised at the discretion of the editor.

For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.

FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

Largest medical schools

Ranked by total active enrollment for the 2016-17 school year

RANK	INSTITUTION	LOCATION	TYPE	NUMBER OF APPLICATIONS	ACTIVE ENROLLMENT[1]	GRADUATES[2]
1	Lake Erie College of Osteopathic Medicine	Erie, Pa.	Osteopathic	9,183	1,497	353
2	Indiana University School of Medicine	Indianapolis	Allopathic	7,315	1,404	327
3	New York Institute of Technology College of Osteopathic Medicine	Glen Head, N.Y.	Osteopathic	6,697	1,354	298
4	University of Illinois College of Medicine	Chicago	Allopathic	7,931	1,321	301
5	Michigan State University College of Osteopathic Medicine	East Lansing, Mich.	Osteopathic	5,389	1,313	300
6	Western University of Health Sciences College of Osteopathic Medicine of the Pacific	Pomona, Calif.	Osteopathic	6,941	1,301	311
7	Wayne State University School of Medicine	Detroit	Allopathic	4,770	1,214	269
8	Philadelphia College of Osteopathic Medicine	Philadelphia	Osteopathic	9,804	1,084	254
9	Sidney Kimmel Medical College at Thomas Jefferson University	Philadelphia	Allopathic	10,726	1,064	249
10	Kansas City University of Medicine and Biosciences, College of Osteopathic Medicine	Kansas City, Mo.	Osteopathic	5,618	1,056	245

[1]Total active enrollment includes students listed as actively enrolled in medical school as of Oct. 31, 2016.

[2]Total number of graduates based on most recent data available.

Sources: Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, originally published in the July 24 issue.

The IBM Watson Health 100 Top Hospitals: National Benchmarks for Success-2017

Listed by category and in alphabetical order

MAJOR TEACHING HOSPITALS	LOCATION	YEARS ON LIST
Advocate Lutheran General Hospital	Park Ridge, Ill.	Eighteen
Baptist Medical Center Jacksonville*	Jacksonville, Fla.	Three
Beaumont Hospital-Royal Oak*	Royal Oak, Mich.	Seven
Emory University Hospital	Atlanta	Three
Houston Methodist Hospital	Houston	Five
NorthShore University HealthSystem	Evanston, Ill.	Eighteen
Northwestern Memorial Hospital	Chicago	Eight
Ochsner Medical Center	New Orleans	Five
OhioHealth Doctors Hospital	Columbus	Seven
Providence-Providence Park Hospital	Southfield, Mich.	Nine
SSM Health St. Mary's Hospital	St. Louis	Two
St. Joseph Mercy Hospital*	Ann Arbor, Mich.	Nine
St. Luke's University Hospital-Bethlehem	Bethlehem, Pa.	Five
University of Colorado Hospital	Aurora	Four
University of Utah Health Care	Salt Lake City	One

TEACHING HOSPITALS (200 OR MORE ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Adventist Medical Center Hinsdale	Hinsdale, Ill.	One
Aspirus Wausau Hospital	Wausau, Wis.	Five
Beaumont Hospital-Grosse Pointe*	Grosse Pointe, Mich.	One
Bethesda North Hospital	Cincinnati	Seven
Billings Clinic Hospital	Billings, Mont.	Five
BSA Health System	Amarillo, Texas	Four
Christ Hospital Health Network	Cincinnati	Seven
Franciscan Health Indianapolis	Indianapolis	Four
IU Health Ball Memorial Hospital	Muncie, Ind.	Two

TEACHING HOSPITALS (CONTINUED) (200 OR MORE ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Kendall Regional Medical Center	Miami	Ten
Lancaster General Hospital	Lancaster, Pa.	Eleven
LDS Hospital	Salt Lake City	Four
Mercy Health St. Mary's	Grand Rapids, Mich.	Two
Mercy Hospital St. Louis	St. Louis	Five
Newton-Wellesley Hospital	Newton, Mass.	Seven
Park Nicollet Methodist Hospital*	St. Louis Park, Minn.	Four
Parkview Regional Medical Center	Fort Wayne, Ind.	Three
Poudre Valley Hospital	Fort Collins, Colo.	Eleven
Riverside Medical Center	Kankakee, Ill.	Eight
Rose Medical Center	Denver	Ten
Sentara Leigh Hospital	Norfolk, Va.	Three
St. Cloud Hospital	St. Cloud, Minn.	Eleven
St. Luke's Boise Medical Center	Boise, Idaho	Nine
St. Mary's Hospital	Madison, Wis.	Four
St. Vincent Healthcare	Billings, Mont.	Two

LARGE COMMUNITY HOSPITALS (250 OR MORE ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Advocate Condell Medical Center	Libertyville, Ill.	Three
Asante Rogue Regional Medical Center	Medford, Ore.	Five
Chandler Regional Medical Center	Chandler, Ariz.	One
Chester County Hospital	West Chester, Pa.	One
Christus Mother Frances Hospital Tyler	Tyler, Texas	Seven
EvergreenHealth Kirkland	Kirkland, Wash.	Two
FirstHealth Moore Regional Hospital	Pinehurst, N.C.	Five

The 100 Top Hospitals National Study has been published for 24 consecutive years.
*One of 10 Everest Winners, hospitals that have achieved the highest current performance and the fastest improvement in the past five years. Everest winners have been published for nine consecutive years.
Source: IBM Watson Health, originally published in the March 6 issue.

LARGE COMMUNITY HOSPITALS (CONTINUED) (250 OR MORE ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Florida Hospital Memorial Medical Center	Daytona Beach, Fla.	Three
Henrico Doctors' Hospital	Richmond, Va.	Two
Logan Regional Hospital	Logan, Utah	Seven
Memorial Hermann Memorial City Medical Center	Houston	Six
Mercy Hospital	Coon Rapids, Minn.	Six
Mosaic Life Care*	St. Joseph, Mo.	Three
North Florida Regional Medical Center	Gainesville, Fla.	Nine
Roper Hospital	Charleston, S.C.	Three
Scripps Memorial Hospital La Jolla	San Diego	Two
St. David's Medical Center	Austin, Texas	Eight
St. Francis Downtown	Greenville, S.C.	Three
WellStar West Georgia Medical Center	LaGrange, Ga.	Two
West Florida Hospital	Pensacola, Fla.	Four

MEDIUM COMMUNITY HOSPITALS (100-249 ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
American Fork Hospital	American Fork, Utah	Seven
Baptist Medical Center Beaches*	Jacksonville Beach, Fla.	One
Baylor Scott & White Health-Round Rock	Round Rock, Texas	Two
Blanchard Valley Hospital	Findlay, Ohio	Five
Bon Secours St. Francis Hospital	Charleston, S.C.	Four
Chino Valley Medical Center	Chino, Calif.	Six
Clermont Hospital	Batavia, Ohio	Eight
Dupont Hospital	Fort Wayne, Ind.	Four
Fairview Park Hospital	Dublin, Ga.	Four
Holland Hospital	Holland, Mich.	Twelve
Inova Fair Oaks Hospital	Fairfax, Va.	Four
Medical Center of the Rockies	Loveland, Colo.	One
Mercy Medical Center	Cedar Rapids, Iowa	Five

MEDIUM COMMUNITY HOSPITALS (CONTINUED) (100-249 ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Ochsner Medical Center-Baton Rouge*	Baton Rouge, La.	Two
Sherman Oaks Hospital	Sherman Oaks, Calif.	Two
St. Alphonsus Medical Center-Nampa	Nampa, Idaho	One
St. Vincent Carmel Hospital	Carmel, Ind.	Four
Sycamore Medical Center	Miamisburg, Ohio	Eight
Texas Health Harris Methodist Hospital Southwest Fort Worth	Fort Worth, Texas	Two
West Valley Medical Center	Caldwell, Idaho	Four

SMALL COMMUNITY HOSPITALS (25-99 ACUTE-CARE BEDS)	LOCATION	YEARS ON LIST
Alta View Hospital	Sandy, Utah	Five
Aurora Medical Center	Two Rivers, Wis.	Two
Aurora Medical Center	Oshkosh, Wis.	Two
Fairview Northland Medical Center	Princeton, Minn.	Two
Franklin Woods Community Hospital	Johnson City, Tenn.	Two
Hawkins County Memorial Hospital*	Rogersville, Tenn.	Two
Henry Community Health	New Castle, Ind.	One
Lakeview Hospital	Bountiful, Utah	Seven
Lakeview Hospital	Stillwater, Minn.	Six
Lakeview Medical Center	Rice Lake, Wis.	Two
Oaklawn Hospital	Marshall, Mich.	Two
OSF St. James-John W. Albrecht Medical Center	Pontiac, Ill.	One
Parkview Huntington Hospital	Huntington, Ind.	Five
Spectrum Health United Hospital	Greenville, Mich.	Seven
Spectrum Health Zeeland Community Hospital	Zeeland, Mich.	Three
St. John Owasso Hospital	Owasso, Okla.	One
St. Joseph Mercy Livingston Hospital*	Howell, Mich.	Three
Texas Health Harris Methodist Hospital Alliance	Fort Worth, Texas	One
Waynesboro Hospital	Waynesboro, Pa.	Two
Yampa Valley Medical Center	Steamboat Springs, Colo.	One

Best Places to Work in Healthcare: Providers/Insurers

RANK	
1	**Texas Health Flower Mound** Flower Mound, Texas | *Provider*
2	**SpineNevada Minimally Invasive Spine Institute** Reno, Nev. | *Provider*
3	**Marathon Health** Winooski, Vt. | *Provider*
4	**The Women's Hospital** Newburgh, Ind. | *Provider*
5	**Black River Memorial Hospital** Black River Falls, Wis. | *Provider*
6	**Beach Cities Health District** Redondo Beach, Calif. | *Provider*
7	**Doctors Hospital of Sarasota** Sarasota, Fla. | *Provider*
8	**Southern Tennessee Regional Health System-Pulaski** Pulaski, Tenn. | *Provider*
9	**Woman's Hospital** Baton Rouge, La. | *Provider*
10	**Texas Orthopedic Hospital** Houston | *Provider*
11	**Memorial Healthcare System** Hollywood, Fla. | *Provider*
12	**Advantage Home Health Services** North Canton, Ohio | *Provider*
13	**Hospice of the Northwest** Mount Vernon, Wash. | *Provider*
14	**Physicians Surgical Hospitals** Amarillo, Texas | *Provider*
15	**York General** York, Neb. | *Provider*
16	**Methodist Ambulatory Surgery Hospital** San Antonio | *Provider*
17	**ReNew Health Group** Monrovia, Calif. | *Provider*
18	**South Broward Endoscopy** Cooper City, Fla. | *Provider*
19	**Encompass Home Health and Hospice** Dallas | *Provider*
20	**Health By Design** San Antonio | *Provider*
21	**Neosho Memorial Regional Medical Center** Chanute, Kan. | *Provider*
22	**Nathan Adelson Hospice** Las Vegas | *Provider*
23	**King's Daughters Medical Center** Brookhaven, Miss. | *Provider*
24	**Texas Institute for Surgery** Dallas | *Provider*
25	**Stillwater Medical Center** Stillwater, Okla. | *Provider*
26	**HopeWest** Grand Junction, Colo. | *Provider*
27	**Methodist Texsan Hospital** San Antonio | *Provider*
28	**West Valley Medical Center** Caldwell, Idaho | *Provider*
29	**Hospice Care of South Carolina** Spartanburg, S.C. | *Provider*
30	**Licking Memorial Health Systems** Newark, Ohio | *Provider*
31	**Bluegrass Care Navigators** Lexington, Ky. | *Provider*
32	**Sutter Davis Hospital** Davis, Calif. | *Provider*
33	**Pelham Medical Center** Greer, S.C. | *Provider*
34	**Orthopaedic Hospital of Wisconsin** Glendale, Wis. | *Provider*
35	**Christus St. Michael Health System** Texarkana, Texas | *Provider*
36	**South Baldwin Regional Medical Center** Foley, Ala. | *Provider*
37	**Lovelace Women's Hospital** Albuquerque | *Provider*
38	**Landmark Health** Huntington Beach, Calif. | *Provider*
39	**Advocate South Suburban Hospital** Hazel Crest, Ill. | *Provider*
40	**Lee's Summit Medical Center** Lee's Summit, Mo. | *Provider*
41	**Henry County Hospital,** Napoleon, Ohio | *Provider*
42	**Neurotech** Waukesha, Wis. | *Provider*
43	**Englewood Community Hospital** Englewood, Fla. | *Provider*
44	**Lafayette Surgical Specialty Hospital** Lafayette, La. | *Provider*
45	**Sutter Center for Psychiatry** Sacramento, Calif. | *Provider*
46	**Self Regional Healthcare** Greenwood, S.C. | *Provider*
47	**Bright Health** Minneapolis | *Insurer*
48	**Acuity Specialty Hospital of New Jersey** Atlantic City, N.J. | *Provider*
49	**Hill Country Memorial Hospital** Fredericksburg, Texas | *Provider*
50	**Hills & Dales General Hospital** Cass City, Mich. | *Provider*
51	**JPS Health Network** Fort Worth, Texas | *Provider*
52	**Christus Shreveport-Bossier Health System** Shreveport, La. | *Provider*
53	**RWJBarnabas Health** West Orange, N.J. | *Provider*
54	**Advocate Sherman Hospital** Elgin, Ill. | *Provider*
55	**HealthSouth Corp.** Birmingham, Ala. | *Provider*
56	**Tri-Cities Cancer Center** Kennewick, Wash. | *Provider*
57	**Advocate Illinois Masonic Medical Center** Chicago | *Provider*
58	**Tanner Health System** Carrollton, Ga. | *Provider*
59	**Hillcrest Hospital Cushing** Cushing, Okla. | *Provider*
60	**Allegan General Hospital** Allegan, Mich. | *Provider*
61	**West Park Hospital** Cody, Wyo. | *Provider*
62	**Bailey Medical Center** Owasso, Okla. | *Provider*
63	**Jamestown Regional Medical Center** Jamestown, N.D. | *Provider*
64	**Hoag Orthopedic Institute** Irvine, Calif. | *Provider*
65	**Lovelace Medical Center** Albuquerque | *Provider*
66	**St. Rita's Health Partners** Lima, Ohio | *Provider*
67	**Metropolitan Methodist Hospital** San Antonio | *Provider*
68	**BSA Health System** Amarillo, Texas | *Provider*
69	**Weber Human Services** Ogden, Utah | *Provider*
70	**Loma Linda University Behavioral Medical Center** Redlands, Calif. | *Provider*
71	**RiverView Health** Crookston, Minn. | *Provider*
72	**Advocate Lutheran General Hospital** Park Ridge, Ill. | *Provider*
73	**Hocking Valley Community Hospital** Logan, Ohio | *Provider*
74	**Hannibal Regional Healthcare System** Hannibal, Mo. | *Provider*
75	**Seton Medical Center Harker Heights** Harker Heights, Texas | *Provider*

Source: Best Companies Group/Modern Healthcare, originally published in an Oct. 2 special supplement.

Best Places to Work in Healthcare: Suppliers

RANK	
1	**Impact Advisors** Naperville, Ill.
2	**CompHealth** Salt Lake City
3	**Medasource** Indianapolis
4	**MyRounding, a Huron company** Denver
5	**BroadJump** Dallas
6	**Talent Plus** Lincoln, Neb.
7	**Burwood Group** Chicago
8	**RNnetwork** Boca Raton, Fla.
9	**Jackson Physician Search** Alpharetta, Ga.
10	**Health Catalyst** Salt Lake City
11	**Crothall Healthcare** Wayne, Pa.
12	**Signature Performance** Omaha, Neb.
13	**Navin Haffty & Associates** Westborough, Mass.
14	**Galen Healthcare Solutions** Chicago
15	**CQuence Health Group** Omaha, Neb.
16	**Aya Healthcare** San Diego
17	**LiquidAgents Healthcare** Plano, Texas
18	**Entrada** Brentwood, Tenn.
19	**MedKoder** Mandeville, La.
20	**MedPartners Locum Tenens** Coral Springs, Fla.
21	**Morrison Healthcare** Sandy Springs, Ga.
22	**The Chartis Group** Chicago
23	**Jellyfish Health** Panama City, Fla.
24	**pMD** San Francisco
25	**MMY Consulting** Indianapolis
26	**CipherHealth** New York
27	**Corazon** Pittsburgh
28	**CAQH** Washington, D.C.
29	**Medicus Healthcare Solutions** Windham, N.H.
30	**Louisiana Organ Procurement Agency** Metairie, La.
31	**Axxess** Dallas
32	**American College of Cardiology** Washington, D.C.
33	**Edifecs** Bellevue, Wash.
34	**axialHealthcare** Nashville
35	**Avia** Chicago
36	**TSI Healthcare** Chapel Hill, N.C.
37	**MedSys Group** Plano, Texas
38	**Weatherby Healthcare** Fort Lauderdale, Fla.

RANK	
39	**J2 Interactive** Charlestown, Mass.
40	**Biotek Labs** Atlanta
41	**Pacific Companies** Aliso Viejo, Calif.
42	**Nordic** Madison, Wis.
43	**Avizia** Reston, Va.
44	**Phreesia** New York
45	**FreemanWhite, a Haskell Company** Charlotte, N.C.
46	**TigerText** Santa Monica, Calif.
47	**Healthfinch** Madison, Wis.
48	**Hayes Management Consulting** Newton Center, Mass.
49	**MediRevv** Coralville, Iowa
50	**Yankee Alliance** Andover, Mass.
51	**Encore, a Quintiles Company** Houston
52	**ABM Healthcare** St. Clair Shores, Mich.
52	**Triage Consulting Group** San Francisco
54	**IMA Consulting** Chadds Ford, Pa.
55	**The Medicus Firm** Dallas
56	**Cumberland Consulting Group** Franklin, Tenn.
57	**Accreditation Commission for Health Care** Cary, N.C.
58	**MedPartners** Coral Springs, Fla.
59	**American Society of Health-System Pharmacists** Bethesda, Md.
60	**Divurgent** Virginia Beach, Va.
61	**Imprivata** Lexington, Mass.
62	**Educational Commission for Foreign Medical Graduates** Philadelphia
63	**Genomind** King of Prussia, Pa.
64	**National Medical Billing Services** Chesterfield, Mo.
65	**Prominence Advisors** Lincolnshire, Ill.
66	**HeartCare Imaging** Tequesta, Fla.
67	**SPM Marketing & Communications** La Grange, Ill.
68	**Pivot Point Consulting, a Vaco Company** Brentwood, Tenn.
69	**Santa Rosa Consulting** Franklin, Tenn.
70	**Quartet** New York
71	**Indiana Health Information Exchange** Indianapolis
72	**Central Logic** South Jordan, Utah
73	**Monarch Medical Technologies** Charlotte, N.C.
74	**Vizient** Irving, Texas
75	**Avaap** Edison, N.J.

Largest patient-satisfaction measurement firms

Ranked by total number of clients in 2016

RANK	COMPANY	HEADQUARTERS (CITY, STATE)	TOTAL NUMBER OF CLIENTS	TOTAL NUMBER OF ENGAGEMENTS*	COMPANY'S LARGEST CLIENT BASE
1	Press Ganey Associates	South Bend, Ind.	221,586	—	Physician groups/clinics
2	NRC Health[1]	Lincoln, Neb.	14,627	75,890	Physician groups/clinics
3	SullivanLuallin Group[2]	San Diego	12,550	1,806	Physician groups/clinics
4	Patient Approved[2]	Glen Burnie, Md.	6,539	6,539	Physician groups/clinics
5	HealthStream	Nashville	6,511	22,745	Physician groups/clinics
6	SPH Analytics	Alpharetta, Ga.	3,288	3,288	Health insurers/managed-care plans
7	Pinnacle QI	Salt Lake City	2,486	2,839	Other healthcare organizations
8	Axxess	Dallas	1,380	2,028	Other healthcare organizations
9	DSS Research	Fort Worth, Texas	1,086	6,288	Other healthcare organizations
10	National Business Research Institute	Plano, Texas	835	835	Physician groups/clinics

Note: Updated ranking to issue correction for placement of SPH Analytics. Information is self-reported from companies responding to Modern Healthcare's survey; only those that participated were considered for this ranking.

*Reflects total number of specific providers/entities contracted in 2016., [1]Formerly National Research Corp., [2]Figures are estimates.

Source: Modern Healthcare's 2017 Patient Satisfaction Measurement Firms Survey, originally published in the Oct. 30 issue.

Largest vendors of electronic health record systems

Ranked by number of hospitals reporting company as primary vendor, 2015

Rank	Vendor (Owner if applicable)	Location	Number of hospitals
1	Epic Systems Corp.	Verona, Wis.	997
2	Cerner Corp.	North Kansas City, Mo.	994
3	Meditech	Westwood, Mass.	935
4	McKesson Corp.	San Francisco	444
5	Medhost	Franklin, Tenn.	333
6	Evident (CPSI)	Mobile, Ala.	272
7	Allscripts	Chicago	243
8	Sunquest Information Systems[1]	Tucson, Ariz.	219
9	YourCareUniversity (Medhost)	Franklin, Tenn.	212
10	Healthland (CPSI)	Glenwood, Minn.	191

Note: Data are self-reported by healthcare providers participating in the Medicare EHR incentive program.
It is summarized from the ONC open dataset, EHR Products Used for Meaningful Use Attestation.

[1]Laboratory focused

Source: Office of the National Coordinator for Health Information Technology, "EHR Developers Reported by Health Care Providers Participating in Federal Programs," August 2017, originally published in the Nov. 27 issue.

Largest revenue-cycle management firms

Ranked by total number of healthcare revenue-cycle contracts, 2016

RANK	FIRM NAME	LOCATION	REVENUE CYCLE FTES[1]	COMPREHENSIVE	PARTIAL	TOTAL CONTRACTS
1	Experian Health	Franklin, Tenn.	800	–	–	4,567
2	SSI Group	Mobile, Ala.	370	–	–	2,800
3	nThrive[1]	Alpharetta, Ga.	3,369	–	–	1,800
4	Parallon	Nashville	15,800	1,010	788	1,798
5	Simplee	Palo Alto, Calif.	81	–	–	1,000
6	Conifer Health Solutions	Frisco, Texas	14,600	–	–	800
7	ClearBalance	San Diego	72	–	734	734
8	PMMC	Charlotte, N.C.	71	–	469	469
9	Navigant Consulting	Chicago	2,440	–	–	424
10	Avadyne Health	Moline, Ill.	425	–	–	354
11	FirstCredit / RevCare	Fairlawn, Ohio	170	260	45	305
12	AGS Health	Newark, N.J.	4,683	245	–	245
13	Crowe Horwath	Chicago	117	12	131	143
14	Healthcare Resources Group	Spokane Valley, Wash.	333	21	118	139
15	Xtend Healthcare	Hendersonville, Tenn.	951	14	118	132
16	GeBBS Healthcare Solutions	Marina del Rey, Calif.	4,500	–	–	93
17	Impact Advisors	Naperville, Ill.	65	9	79	88
18	Kohler HealthCare Consulting	Woodstock, Md.	10	12	67	79
19	Gaffey Healthcare	Plano, Texas	50	–	–	65
20	KPMG	New York	150	10	50	60

Information is self-reported from companies responding to Modern Healthcare's survey; only those that participated were considered for this ranking. Comprehensive contracts include all patient-access services, healthcare information management and patient financial services. Partial contracts represent limited components such as self-pay collections and claims-denial management.

*Total full-time equivalent employees who spent at least 50% of their time on revenue-cycle services as of Dec. 31, 2016.

[1]Formerly Precyse

Source: Modern Healthcare's 2017 Revenue-Cycle Firms Survey, originally published in the Sept. 18 issue.

Information in this chart subsequently may be revised at the discretion of the editor.

For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.

FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

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Finance companies with the largest healthcare loan portfolios

Ranked by amount of loans underwritten in 2016

RANK	BOOKRUNNER	LOANS UNDERWRITTEN ($ IN MILLIONS)	NUMBER OF LOANS	MARKET SHARE PERCENTAGE
1	Bank of America Merrill Lynch	$50,887	81	16.9%
2	JPMorgan Chase & Co.	33,191	83	11.0
3	Barclays	24,579	42	8.1
4	Citigroup	19,237	42	6.4
5	Morgan Stanley	15,313	19	5.1
6	Deutsche Bank	14,213	31	4.7
7	Goldman Sachs	12,831	25	4.3
8	Wells Fargo Securities	12,013	50	4.0
9	Mitsubishi UFJ Financial Group	8,975	32	3.0
10	BNP Paribas	7,947	21	2.6
11	Mizuho Financial Group	7,063	35	2.3
12	Sumitomo Mitsui Financial Group	6,152	34	2.0
13	HSBC	6,125	17	2.0
14	Credit Suisse	6,064	20	2.0
15	Credit Agricole CIB	4,630	9	1.5
16	SG Corporate & Investment Banking	4,416	8	1.5
17	SunTrust Robinson Humphrey	4,254	25	1.4
18	ING Group	4,159	10	1.4
19	UniCredit	4,109	12	1.4
20	Jefferies	3,954	19	1.3

Source: Dealogic, originaly published in the Jan. 30 issue.

For more information on the data used to complete this chart. Contact Dealogic,
120 Broadway, 8th floor, New York, NY 10271; 212-577-4400; Dealogic.com

Information in this chart subsequently may be revised at the discretion of the editor.
For more information on our research department at **312-649-5471** or **mcaruso@modernhealthcare.com**.
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