HealthLeaders Media
A Division of hcPro

HEALTHCARE
STRATEGIC MANAGEMENT

The bottom line in healthcare marketing

November 2007
Vol. 25 No. 11

INSIDE

- How will physician extenders affect our need for physicians? 4

Physician relations:
- Changing times call for changing roles 6

Worth reading:
- Crafting physician surveys: Know what you're looking for 8

Statistical notes:
- Study: Rise in prescription drug injuries 10

Research notes:
- Parental surveys boost diagnosis capabilities of doctors 12

Strategic notes:
- Ohio billboards turning heads 14

A *HealthLeaders* Media publication

Branding

Is your brand a communications strategy or a business strategy?

To succeed, the entire community must fulfill promise

by Maureen O. Larkin

As any good marketer knows, a brand is more than a logo used in your print advertising. It's more than a slogan heard by radio listeners. It's a promise to consumers that your hospital will deliver the kind of care they need. If implemented correctly, a hospital's brand can drive business and growth for the organization.

For WellStar, a five-hospital system near Atlanta, the brand "We Believe" has allowed the hospital system to market many of its different clinical offerings, as well as get across the message of quality care.

The "We Believe" brand has positioned the health system as an organization that cares about not just medicine but overall quality of life for Georgia residents. "We wanted a brand statement that we could take and build out," said **Kim Menefee,** senior vice president for public/governmental affairs. "We wanted something we could use across all service lines."

WellStar's rebranding process was the subject of a presentation at the October 2007 Society for Healthcare Strategy and Market Development (SHSMD) annual education conference and exhibits in Washington, DC.

WellStar expects more than 130,000 new residents to move into its four-county service area during the next 10 years, said Menefee. The area's low cost of living and high quality of life make it an attractive area for families to settle in. To handle this population growth, WellStar formed a strategic plan in 2002. Part of this plan was to "differentiate the WellStar brand," said Menefee.

> "We wanted to move beyond high-quality healthcare **and create emotional satisfaction.**"
> *—Kim Menefee*

As administrators set out to find a brand that accurately described the hospital system, they knew there were several key attributes that should be a part of the new brand: world-class expertise, cutting-edge technology, and innovative health services.

They also wanted the brand to emphasize people, achievement, a state of health, and well-being.

WellStar had a reputation for high-quality healthcare and hoped to continue that reputation, adding high emotional satisfaction to the mix.

"We wanted to move beyond high-quality healthcare and create emotional satisfaction," Menefee said.

The result was "We Believe," a brand that was used at first to introduce the hospital to the

continued on p. 2

Branding

continued from p. 1

growing population in metropolitan Atlanta, and eventually used to promote the system's key service lines.

Branding to win

A good branding effort not only puts you front-of-mind when it comes to your customers, but it also becomes a large part of your business strategy, said **Karen Corrigan,** CEO of The Strategy Group, a Norfolk, VA–based healthcare consultancy firm. Corrigan worked with WellStar to develop its brand and spoke at SHSMD.

Traditionally associated with big-name retail stores, food items, and clothing companies, **big brands are now entering the healthcare arena.**

"If I'm FedEx, and what you know about me, what you believe, is absolutely, positively overnight delivery, then everything about my business strategy has to be realigned to meet this goal," Corrigan said.

Traditionally associated with big-name retail stores, food items, and clothing companies, big brands are now entering the healthcare arena, she said.

Consumer values and expectations for quality and access are intensifying, she said, meaning that hospitals are competing harder than ever for business. Securing your brand and giving consumers the "brand experience" is more important than ever, Corrigan added.

"Today, deductibles and copays are going higher, and more is coming out of my pocket," she said. Consumers are getting more choosy about their healthcare, and they have more choices than ever. Included in those choices are retail clinics, which are opening under very recognizable brands of convenience, such as Wal-Mart, Target, and CVS.

"These clinics are a sign of what we're about to see," Corrigan said. "There are more retail possibilities in healthcare, but they won't be developed by healthcare organizations."

These new developments require a shift in our perspective on competition, Corrigan said.

"Healthcare has always been supply-side driven, the industry is just set up that way," Corrigan said. "Ten years ago, you wouldn't have found a primary care physician that thought Wal-Mart was one of [his or her] competitors."

Branding has traditionally been a communications strategy, but it's time for every hospital to make it a business strategy, Corrigan said.

"Brand perceptions drive customer behaviors, which drive business outcomes," she said. "This is probably the most important formula to put in front of your executive team on a daily basis."

Getting everyone on board

To convince the public that WellStar's slogan, "We Believe in Life Well-Lived," was genuine, Menefee and her fellow marketers needed to get the entire health system staff on board.

"It was a big challenge for us to integrate the operations side and the marketing side and be able to deliver" on the brand promise, Menefee said. WellStar wanted its hospitals to have a culture of employees who "live the brand," she added.

To get all staff members on board, Menefee said, she first communicated the "We Believe" brand promise to all leadership staff in 2003, and over the next two years put on various events and activities to communicate the brand to all staff members.

All employees were given T-shirts with the "We Believe" message, and Menefee said it didn't take long before employees were offering their own versions of the "We Believe" slogan.

Getting this buy-in from staff members is important, said Corrigan.

"You're out to create a marketing culture that goes beyond the walls of the marketing department," she said.

Living the brand

When WellStar introduced the brand "We Believe in Life Well-Lived," the hospital was able to use it to market services that made it different from other hospital systems in Georgia.

One of these services is the CyberKnife, a tool that allows surgeons to remove tumors and other growths without an incision.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

"We were the first in Georgia to have this, and we were very excited to add this technology to our community," Menefee said.

The WellStar Institute for Better Health, an organization launched to the business community in October 2006, aimed to address key health issues, such as diabetes and obesity, to attempt to gain a reputation as a hospital that cares about its patients' overall wellness. The health system also helped area businesses begin the HealthStart program, which encouraged businesses to provide lower-cost health insurance to their employees.

"One of the fallacies of competitive strategy is that it's about being better than your competition," Corrigan said. "Actually, it's being different than your competitors."

By starting the WellStar Institute for Better Health and the HealthStart program and bringing the CyberKnife to its cancer center, WellStar was showing its community that it lived up to the "We Believe" promise and would take action to contribute to the community's overall health. With these programs, it also differentiated itself from its competition.

This differentiation seems to be working for WellStar. From 2000 to 2006, the health system captured 67% of new market growth in metropolitan Atlanta, Menefee said.

Delivering what you promise—as WellStar did—is key, Corrigan said. "What you advertise builds awareness. What you deliver builds your brand."

Upcoming Webcasts

Marketing to Women: Proven techniques to reach key healthcare decision-makers

Live Webcast

Thursday, November 15

1–2:30 p.m. (EST)

During this Webcast learn how targeting women with effective marketing and programs directly affects your hospital's bottom line. Hear from two hospitals that are reaping the benefits of marketing to women, as well as a healthcare marketing consultant who will dig down into the key niches of the female demographic. Get innovative ideas you can implement to bring in new and recurring business for your healthcare organization.

Marketing Orthopedic Service Lines

Live Webcast

Thursday, December 13

1–2:30 p.m. (EST)

Thinking about launching a campaign to market your hospital's orthopedic services? Before you do, taking time to research and ask questions can ensure your marketing dollars are wisely spent. In this 90-minute Webcast, market research specialists will outline the things every marketer should know when considering an orthopedics campaign, including whether the timing is right for your message in the market. Hear from one of your hospital marketing colleagues, who will share the story of his institution's latest orthopedics campaign and the importance of branding your service line.

To participate in this Webcast, visit *www.hcmarketplace.com* or call HCPro customer service at 877/727-1728.

Marketing for healthcare is a unique challenge.

Let us guide you.

Subscribe to this FREE e-newsletter today for original content and timely analysis on the hottest marketing topics including:

- Physician sales and relations
- Measuring ROI
- Business development
- Marketing service lines
- Public relations
- Fund raising and much more!

Sign up for FREE!

www.healthleadersmedia.com/marketing

HealthLeaders Media

©2007 HealthLeaders Media

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Healthcare trends

How will physician extenders affect our need for physicians?

by H.J. Simmons III, MBA, CHE, and Dayana Habib Rapoport, MHA

In last month's **Healthcare Strategic Management,** DGA Partners provided a set of physician-to-population ratios.

Although these standards allow for a relatively simple calculation of physician demand, quantifying physician supply is not an easy task.

Further complicating the issue is the increasing use of physician extenders in providing services traditionally provided by physicians. Incorporating physician extenders into a physician manpower analysis to better understand a community's need is becoming more and more relevant, especially in rural markets.

The number of physician extenders, including nurse practitioners (NP), physician assistants (PA), and certified nurse midwives, has grown substantially over the past five years, due largely to their expanded roles in delivering health care services. **Table 1** below illustrates this growth.

Given the projected shortage of physicians, the number of physician extenders is likely to continue to increase. However, a limiting factor in the increased use and acceptance of physician extenders is the regulatory and professional restrictions imposed on the scope of their practice.

Although there has been progress in the effort to create national standards for licensure requirements and clinical responsibilities of physician extenders, they still vary greatly by state, according to the article "The Changing Professional Practice of Physician Assistants: 1992 to 2000" in the January 2004 *Journal of the American Academy of Physician Assistants.*

Due to this lack of consistency, it is difficult to incorporate the effect of physician extenders into the physician-to-population ratios used in projecting physician demand. Rather, DGA believes it is more helpful to provide some guidelines for including physician extenders in the supply side of the community need equation.

The U.S. Department of Health and Human Services (HHS) proposed nearly a decade ago to quantify the full-time equivalency of NPs and PAs to be incorporated into

Table 1

Growth in physician extenders 2000–2005

	2000	2005	Average annual percent change
Nurse practitioners*	102,649	152,929	8.30%
Physician assistants**	45,311	58,665	5.30%
Certified nurse midwives***	447	2,236	38%

*Number of nurse practitioners comes from the *National Sample Survey of Registered Nurses March 2004: Preliminary Findings* (Health Resources Services Administration, 2005). Numbers in this report are for 2000 and March 2004 (141,279). The average annual percent change from 2000–2004 was used to calculate the estimated 2005 figure.

**Physician assistant statistics provided by the American Academy of Physician Assistants. 2005 number reflects estimate as of December 31, 2005.

***Certified nurse midwives figures provided by the American Academy of Nurse-Midwives

Source: DGA Partners.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

their definition of a Medically Underserved Area population and Health Professional Shortage Area at 0.5 full-time equivalent (FTE).

Ideally, this 0.5 FTE would need to be adjusted for various markets. In 2004, HHS' Bureau of Health Professions published a report that provided a score for each state and the District of Columbia based on then existing regulations for physician extender practices.

Scoring was based on legal status, reimbursement, and authority to write prescriptions, with 0 representing the lowest score and 100 the highest.

Table 2

Score range	Adjusted values
0–10	(0.5)
11–20	(0.4)
21–30	(0.3)
31–40	(0.2)
41–50	(0.1)
51–60	0.00
61–70	0.15
71–80	0.20
81–90	0.25
91–100	0.30

Source: DGA Partners.

Although not perfect, this scoring system can be used as a guide to adjust the 0.5 FTE benchmark, but the planner must first verify that the state in which he or she is performing the analysis has not significantly altered the regulatory requirement with regard to physician extenders. In this same report, state regulatory requirements for physician extenders are summarized for 2000, offering a base of comparison for planners to utilize.

Using the HHS FTE benchmark and the scoring system, a value can be developed for physician extenders in each state. In **Table 2,** DGA has converted the scoring ranges to an adjuster value scale. Under this methodology, a physician extender can be excluded from the physician supply count (at the lower end of the adjuster value scale) or included in the count at a maximum value of 0.8 FTE.

When applied to selected states, **Table 3** shows the variations that can occur when applying this methodology to physician extenders in physician manpower planning.

Whether physician extenders can be effectively incorporated into the physician-to-population ratios remains a key question and is dependent on national standards of licensure requirements and clinical responsibilities. In the interim, the inclusion of their effect on the supply side of the equation will provide a more accurate indication of physician need. ■

Editor's note: Simmons is a principal and Rapoport is a consultant with DGA Partners, a Philadelphia-based healthcare management consulting firm. They can be reached by telephone at 610/667-8782.

Table 3

State[1]	Base FTE	Physician assistants			Nurse practitioners			Certified nurse midwives		
		Score	Adjuster	FTE	Score	Adjuster	FTE	Score	Adjuster	FTE
California	0.5	83	0.25	0.75	84	0.25	0.75	60	0.15	0.65
Minnesota	0.5	81	0.25	0.75	86	0.25	0.75	84	0.25	0.75
Mississippi	0.5	49	(0.10)	0.40	59	0.00	0.50	54	0.00	0.50
New Jersey	0.5	48	(0.10)	0.40	82.5	0.25	0.75	55	0.00	0.50
Pennsylvania	0.5	73	0.20	0.70	73	0.20	0.70	52	0.00	0.50

1. A score can be calculated for each state and the District of Columbia. The five shown in this table are a representative sample.

Source: DGA Partners.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Physician relations

Changing times call for changing roles

by Kriss Barlow, RN, MBA

We've all seen the numbers and know they paint a future with too few physicians to meet the ever-growing need for healthcare. The Council on Graduate Medical Education projects a shortage of 96,000 doctors by 2020. Obviously, the implication for healthcare leaders is huge. Organizations are sure to recognize the effect on planned program expansions; access issues and backlogs for securing hospital services must be part of the equation. CFOs and business development teams are working hard to create never-before considered models for employment to ensure tenure and more/different partnership models.

What's ahead?

Beyond the strategic business decisions, the question is, "How will a shortage affect the day-to-day relationship processes for us?" Aside from the obvious supply and demand economics, there will be changes in hospital and clinic functioning. It's likely you've seen many of the following—and perhaps some others:

- Increased tension
- Decreased physician involvement
- Increased physician clout in their negotiations
- Increased emphasis on efficiency for the physician
- Increased need for physician support staff (physician's assistants, nurse practitioners, and others)
- Increased pressure for the physician recruiter
- Increased challenges for physician relations sales staff
- Increasing shifts by employers to ensure their health plans offer adequate physician access

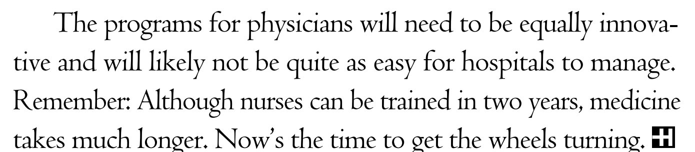
Shoring up your plan

The following are steps you can take to avoid or alleviate some pain if a shortage occurs:

- Create a formal process for talking about this now. The best crisis planning happens before the crisis.
- Promote a culture that invests in learning about the physician's world and their needs and explore collaboration early on. Physician-friendly cultures are hard to develop and never happen overnight.
- Encourage your physician relations team to gather information for leaders and to provide regular exchange about the topic with practices.
- Begin to create a short-run vs. long-run model, especially in the specialty areas where you're likely most vulnerable.
- Formalize physician retention for any new physician so that there's a two-year plan that includes lifestyle, practice, and medical staff integration.
- Ensure you have an internal database to track who's here, who's nearing retirement, and who's been a past, present, or future candidate for physician recruitment.

None of this happens quickly, so make sure you solidify your internal communication—and that includes consistent reminders of your strategy. If you're actively involved in relationship building with staff members, start gathering information from them. Relationship sales teams can start by simply asking, "Have your medical society meetings included discussions of the future physician supply?" and "What affect do you believe it will have on your practice and in our community?" Dialog is healthy and provides wonderful intelligence for the leadership team.

As we look to the future, we can learn from the nursing shortage that healthcare is currently experiencing. Hospitals have taken the lead with innovative methods to manage in the short run as they encourage more to join the nursing profession. There are programs across this country to encourage young people to enter the profession, to enhance the compensation, and to provide flexible work schedules that allow nurses who are out of the work force to return.



The programs for physicians will need to be equally innovative and will likely not be quite as easy for hospitals to manage. Remember: Although nurses can be trained in two years, medicine takes much longer. Now's the time to get the wheels turning.

Editor's note: Barlow is a principal with Barlow/McCarthy, a consulting firm focused on hospital-physician solutions, and author of A Marketer's Guide to Physician Relations: Best Practices for Successful Sales Programs, *published by HealthLeaders Media, a division of HCPro, Inc., in Marblehead, MA. Contact her at* kbarlow@barlowmccarthy.com *or by phone at 715/381-1171.*

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

"Strategic Planning & Marketing Solutions *from Thomson Healthcare helped our team at Tallahassee Memorial HealthCare create effective strategic business plans based on accurate demand forecasts. The result was increased market share in three of our primary counties by 23%, 12%, and 4%.*"

G. Mark O'Bryant

PRESIDENT & CHIEF EXECUTIVE OFFICER
TALLAHASSEE MEMORIAL HEALTHCARE

Better numbers. Better care.

Strategic Planning & Marketing Solutions from Thomson Healthcare helped Tallahassee Memorial develop demand projections in all the counties it services down to the DRG for each service line. This initiative, led by vice president & chief performance improvement officer Cynthia Blair, enabled Tallahassee Memorial to identify which service lines needed improvement, and where to focus efforts. Now that's a win-win situation.

Thomson Healthcare is the market leader in healthcare information products, offering both unparalleled benchmarking services *and* the insight you need to make the data pay off by driving business growth, managing costs, and improving patient care.

Thomson Healthcare
(800) 366-7526
www.thomsonhealthcare.com

Medstat & Solucient are part of Thomson Healthcare.

©2007 Thomson Healthcare
All rights reserved.

Medstat • MercuryMD • Micromedex • PDR • Solucient

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

Worth reading

Crafting physician surveys: Know what you're looking for

Keeping tabs on what troubles physicians on the medical staff can be a tricky endeavor.

Complaints and issues will arise, of course, but there comes a time when an organized assessment of what truly bothers medical staff members needs to be done—and one of the most efficient methods for doing so is through a physician satisfaction survey.

However, simply picking an existing form and sending it to the medical staff may not be good enough; your survey must effectively address your organization's unique requirements and take into account your institutional personality.

The trick is to know exactly what you are looking for. West Virginia University Hospitals, Inc., (WVU) in Morgantown, implemented a physician satisfaction survey in 2006 based on a Medical Group Management Association template.

"We've been focusing on improving physician satisfaction for a while now, and we were trying to determine the best method for capturing audience opinion," says Michele Garlick, assistant to the vice president of medical affairs at WVU.

They decided to ask specific questions that addressed known problems, such as communication and service issues.

"We focused on what services we provided to the physicians, and where we were lacking, asking them if they were satisfied with the level of services provided," says Garlick.

Caldwell Memorial Hospital in Lenoir, NC, developed a physician satisfaction survey four years ago that it distributes annually to all active staff physicians.

The results of the survey are tallied and presented to hospital administration and the medical executive committee for their review and input as medical staff leaders.

Although the surveys are used primarily to spot negative trends, keep in mind that they can also be used to pinpoint what the hospital is doing right, says Tiffany Cooper, medical staff services coordinator for Caldwell Memorial.

Some facilities, such as Kettering (OH) Medical Center, find the use of an outside vendor more appropriate to their needs than developing an in-house survey.

The most important part of choosing an outside vendor is ensuring that it has the capability to meet the specific needs of your organization, says Melissa Walters, manager of medical staff services for Kettering.

In many cases, the results of the surveys may not be surprising, but the availability of tangible numbers regarding physician concerns or complaints will allow for appropriate action to address those issues.

Garlick says the results showed a number of areas with low satisfaction levels that immediately became part of the performance improvement plan for 2007, with a goal to raise satisfaction by 5%–10% in the following year.

See **Health Governance Report,** *October 2007, p. 6.*

It's all about the service

As chair and CEO of Loews Hotels, Jonathan Tisch understands the importance of customer satisfaction. His recent book, *Chocolates on the Pillow Aren't Enough: Reinventing the Customer Experience*, stresses the importance of making the customer experience memorable—even in healthcare, where often the only experiences patients remember are the bad ones.

On the similarities of healthcare and hospitality: It's about taking care of individuals who are entrusting an experience to you, the provider. When people leave the safety and security of their own homes, they are going to an environment that they might not be familiar with.

The unknown is what often scares people. If you can work hard to reassure them in terms of the

Relocating?

If you're relocating or taking a new job and would like to continue receiving **HSM**, you are eligible for a free trial subscription. Contact customer service with your moving information at **800/650-6787**. At the time of your call, please share with us the name of your replacement.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Worth reading

basics—comfort, dining, and a sense of caring—you've gone a long way to covering the concerns that people bring to your facility.

On putting the "service" back in the service industry: We all have nice rooms and marble in the lobby and flat screen TVs, and we've upgraded our bedding product.

But the real way you differentiate yourself from the competition is the attitude and the willingness of you and your coworkers to understand service and be able to offer value. Hospitals are in a similar situation.

Look at the dedication of the nursing staff and the medical team. They factor into it because that's what people relate to. Human beings relate to human beings.

On the importance of first impressions: When someone is checking in, he or she is immediately doing a mental calculation: Is it clean? Is it safe? Am I going to be comfortable?

How do you make people feel comfortable in an environment that is unsettling to begin with?

It's a daunting task, but hospitals now are reaching out to the lodging industry to find ways they can all work together.

On compensating for subpar facilities: In my business, you can overcome them with great service, but keep in mind that the competition is such that there will most likely be someone offering a newer product and wonderful service.

That gets to the competitive nature of business today, whether it's in lodging or in healthcare. There are a lot of smart, well-capitalized people out there who are finding ways to do it better than the competition, and that's why it's in the best interest of any type of service sector business to understand the intersection of physical product and the ability of humans to do the best they can to make their company or their particular hotel or hospital stand out.

See **HealthLeaders** *magazine, September 2007, p.58.*

Passport to the OR

When faced with a need for surgery, a growing number of Americans are deciding to seek treatment outside the country.

The reasons they cite typically include cost savings, little or no wait time, first-class accommodations, and the ability to see the world. However, researching surgeons and facilities abroad on your own can be a daunting task.

To meet this growing demand, medical tourism companies like Calabasas, CA–based PlanetHospital (*www.planethospital.com*) are developing a presence on the Web.

Founded in 2002, PlanetHospital and its offices in the Middle East and France provide patients with a soup-to-nuts solution.

PlanetHospital enlists a team of doctors and nurses who help patients outsource their surgical procedures by selecting from several facilities and surgeons that the company has researched and handpicked.

"We look for high-quality and high-caliber surgeons from around the world who charge significantly less for the same quality of care that one can expect in America," says Rudy Rupak, PlanetHospital founder and president. He says he discovers most of the physicians from published articles in medical journals.

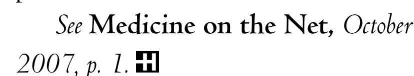
After patients speak with the surgeon about their upcoming procedure, the company arranges all of the necessary appointments, passports, visas, airline tickets, and hotel accommodations.

Rupak, who describes PlanetHospital's role as that of facilitator, says that the company doesn't charge anything more for the treatment than patients would pay themselves. In return, the company charges a $360 concierge fee and a $30 charge to send physical records.

No federal agency in the United States currently tracks the number of citizens who travel abroad for medical treatment, and receiving overseas medical care is not the cure-all for everyone. Consider the conditions that need to be treated.

For example, those who suffer from respiratory illnesses may want to consider the oppressive heat experienced in many third-world countries. And those seeking orthopedic care, such as a hip or knee replacement, should factor in the long flights that are sometimes necessary to travel to places like India.

See **Medicine on the Net,** *October 2007, p. 1.*



For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Statistical notes

Study: Rise in prescription drug injuries

The AMA says the number of serious drug-related injuries more than doubled between 1998 and 2005, and deaths nearly tripled in the same time period.

> Nationally, healthcare spending per capita increased by an average of **6.3% per year from 1998 to 2004.**

According to *The Philadelphia Inquirer*, the rise in adverse events indicates a number of problems with the government's regulation of drugs before they are approved and after they are on the market. The report found the U.S. Food and Drug Administration, doctors, hospitals, and other caregivers wanting in their regulation of medication. Insulin was listed among the top drugs that cause severe disabilities.

In 1998, there were 34,966 serious adverse events, a number that increased to 89,842 in 2005. The number of fatal events increased from 5,519 in 1998 to 15,107 in 2005. Thomas J. Moore, lead author of the study and a senior scientist at the Institute for Safe Medication Practices of Huntingdon Valley, PA, said drugs that had been withdrawn for safety reasons represented only a modest share of the events. The drugs most often resulting in fatal events were disproportionately painkillers and immune system modifiers.

Northeast spends most on healthcare

Compared to a national average of $5,283 per person, annual healthcare spending totaled $6,409 per person in New England and $6,151 in the rest of the Northeast, according to a report in *USA Today* released by the Centers for Medicare & Medicaid Services (CMS).

Nationally, healthcare spending per capita increased by an average of 6.3% per year from 1998 to 2004. The highest per capita spending was Washington, DC, with $8,295, followed by Massachusetts with $6,683, Maine with $6,540, and New York with $6,535.

According to Anne Martin, co-author of the report and an economist with the CMS Office of the Actuary, many of the highest-spending states share similar characteristics, such as high personal incomes, high concentrations of physicians, generous Medicaid programs, and low numbers of uninsured patients.

The study also found that spending patterns vary widely among states as they try to improve coverage. California's spending was $4,638, or 12% lower than the national average, but Massachusetts was nearly 27% higher than the national average. California had an above-average share of the uninsured population, a higher percentage of HMO enrollees, and a below-average percentage of the population under age 65. The only state outside the Northeast to top $6,000 per person was Alaska, with $6,450.

Studies: Men more likely to receive heart devices

Researchers at Duke University have concluded in two studies that men are more likely to receive implantable defibrillators to prevent cardiac arrest, *The Wall Street Journal* reports.

One study examines Medicare claims records from 1991 to 2005, with most of the analysis focusing on 1999–2005; it was during this time that researchers say Medicare coverage for the devices expanded. The study was funded by the National Institutes of Health and involved more than 200,000 Medicare patients. On average, men received defibrillators two to three times more often than women, although more than 60% of the patients eligible for the device do not receive it.

Another study examined more than 13,034 patients admitted to 217 hospitals from January 2005 to June 2007. All of the patients showed heart failure with left ventricular ejection fraction of 30% or less, a measure of how efficiently the heart pumps blood. All of the patients are eligible for implantable defibrillators, but 4,615 (35.4%) had defibrillators at time of discharge or had plans to get one. Women were 40% less likely to receive a defibrillator, and black patients were 30% less likely to receive the device than white patients.

Study: Reducing docs' hours won't reduce death rate

Two studies have concluded that reducing the work hours of doctors-in-training has no significant effect on

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Statistical notes

reducing patient death. According to Newsday.com, death rates dropped in only one of four groups. Authors of the study call it the largest and most comprehensive look at the work-hour reductions, which began four years ago.

Kevin Volpp, MD, PhD, is lead author of one study and a physician at the Philadelphia Veteran Affairs Medical Center. The studies included more than 8.5 million Medicare patients and 318,000 Veterans Affairs (VA) patients and examined deaths within one month of hospital admission before and after 2003.

The reduction of hours from 100 per week to 80 has supporters and detractors; some say it reduces medical mistakes, and others say it fosters a shift-work mentality.

One study concluded that two years after the rule change, mortality improved by 11%–14% in major teaching hospitals. There were no changes in mortality rates for VA surgical patients.

Volpp says the lack of change may be the result of more patient handoffs by residents or lax enforcement of work hours.

The regulations also say residents must have a minimum of 10 hours rest between shifts and may not work more than 24 hours straight.

U.S. life expectancy hits new high

According to a report released by the Centers for Disease Control and Prevention, a child born in 2005 can expect to live nearly 78 years. The report, which was conducted by the National Center for Health Statistics, is based on approximately 99% of death records from 50 states and the District of Columbia and documents the most recent trends in the leading causes of death and infant mortality.

These most recent findings are part of a trend that has seen life expectancy increase from 69.6 years in 1955 to 75.8 years in 1995. Other findings are that the life expectancy for the white population remained the same, at 78.3, while the expectancy for the black population increased slightly from 73.1 years in 2004 to 73.2 years in 2005.

The three leading killers in the United States are heart disease, cancer, and stroke, but instances of all three declined in 2005. Heart disease fell from 217 deaths per 100,000 in 2004 to 210 in 2005; cancer from 185 deaths per 100,000 to 183 deaths per 100,000; and stroke from 50 deaths per 100,000 to 46 deaths per 100,000. Among infants, the mortality rate increased slightly from 6.79 per 1,000 live births to 6.89, with congenital malformations and disorders related to preterm birth and low birth weight the greatest threats.

Majority of women unaware of cholesterol level

A recent survey by the Society for Women's Health Research revealed that 80% of American women aged 18–44 don't know their cholesterol level, even though cholesterol can contribute to heart disease, the number one killer of American women.

According to *Medical News Today*, 50% of the women surveyed were generally concerned about cholesterol, but only one in five knew what her personal cholesterol level was. Nearly 25% were unaware of how cholesterol levels are tested.

The three leading killers in the United States are **heart disease, cancer, and stroke, but instances of all three declined in 2005.**

Mary Ann Bauman, MD, a spokesperson for the American Heart Association, says a number of factors could distract women from the dangers of high cholesterol; many ignore themselves and look after families, are more concerned about breast cancer, and do not have the same fear of heart disease that men do.

According to the National Heart, Lung, and Blood Institute's National Cholesterol Education Program, nearly half of Americans have high cholesterol, which raises the risk of angina, stroke, heart disease, and heart attack.

Bauman said those with a family history of heart disease or high cholesterol should begin cholesterol screening before the recommended age of 20.

Other contributors to heart disease include smoking, high blood pressure, diabetes, obesity, and a sedentary lifestyle.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Research notes

Parental surveys boost diagnosis capabilities of doctors

A survey developed by researchers at the University of Oregon has been credited with a 224% increase in the referral rate of toddlers with minor developmental disabilities.

> The data revealed that in many cases, physicians suspect developmental delays in children, who are almost always eligible for early intervention, **but are prevented from completing the diagnosis.**

According to *Medical News Today*, the questionnaire can be filled out in less than 15 minutes by parents before or after a visit to the doctor, and is dramatically boosting the referrals of the one- to two-year-old target group. Doctors who participated in the one-year study noticed that 53 of the 78 referrals to special services or additional monitoring would not have taken place without the Ages & Stages Questionnaire.

A 54% return rate of the survey, which was given to 1,428 parents, as well as a 15% decrease in patient volume compared to the control year did little to slow the 224% boost. The data revealed that in many cases, physicians suspect developmental delays in children, who are almost always eligible for early intervention, but are prevented from completing the diagnosis because of tight scheduling, high patient volume, and busy offices.

The study also found that physicians have difficulty diagnosing delays at one year compared to two years, even though researchers believe 12%–16% of American children have developmental delays.

Study: Women less likely to change habits, decrease heart disease risk

A recent study published in the *American Heart Journal* concluded that women are less likely to quit behaviors like smoking and infrequent exercise and are more likely than men to engage in harmful lifestyle choices, even when they have a family history of heart disease.

According to *Medical News Today*, the researchers surveyed more than 2,400 people aged 30–50, and defined heart disease risk as a first-degree relative with a history of heart attacks before 50 if male and 55 if female. Fewer women suffer from cardiovascular disease than men, but occurrences are twice as likely to be fatal, said Amit Khera, MD, assistant professor of internal medicine and senior author of the study.

More than 6,000 participants in Dallas County, TX, submitted blood pressure and heart rate measurements, filled out surveys, and had imaging tests that looked for calcium buildup in the coronary arteries. Of this number, young women with family histories of heart disease had higher rates of tobacco use (40% compared to 25% of healthy females) and unhealthy body mass indexes (51% compared to 44% without histories). The *Dallas Heart Study* is funded by the Donald W. Reynolds Foundation, and additional funding came from the National Institute of Mental Health.

Cleveland Clinic uncovers new heart disease trigger

Researchers at Cleveland Clinic's Lerner Research Institute have discovered a mechanism that leads to arterial hardening and may explain why heart disease strikes different segments of the population.

According to a study to be published in the November edition of *Natural Medicine*, the mechanism is found in traditionally high-risk segments of the public—smokers and those suffering from kidney disease—as well as the general population.

Proteins in the bloodstream are damaged by a process called carbamylation, at which point they change the ways cells behave and cause the buildup of harmful substances in the arteries.

In the study of 1,000 patients, doctors discovered that atherosclerosis, or hardening of the arteries, occurs in varying degrees in all segments of the population, but to a greater extent in smokers. The study also shows that high cholesterol alone is not the only cause of heart disease.

A blood test measuring levels of homocitrulline, a molecular indicator of trouble, is the clearest indicator of heart disease or complications to date, said Stanley Hazen, MD, PhD, a researcher in the Lerner

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Research notes

Research Institute and Section Head of Preventative Cardiology. The test could be key in the early diagnosis and treatment of heart disease, and could also be used to gauge the effectiveness of different heart disease treatments.

Internet of little use for hospital data

Researchers at the University of California Los Angeles School of Medicine have found that patients who depend on the Internet to gauge the quality of a hospital prior to their surgery often receive conflicting and incomplete information.

According to *HealthDay News*, Michael Leonardi, MD, and his colleagues sought information about how hospitals are rated for fairly common procedures, such as laparoscopic gallbladder removal, hernia repair, and colon removal. After studying six publicly available Web sites that offer comparisons of hospital quality for more than a year, Leonardi and his group found that the Internet provided "suboptimal measures of quality and inconsistent results" and that much of the information is out of date by more than a year. Their study is reported in *Archives of Surgery*.

Half of the Web sites are privately owned and operated by companies whose names were not released in the study. None of the sites had data available in real time. The other three sites were public or nonprofit. One of the sites used by the group was the government's Centers for Medicare & Medicaid Services.

The public and nonprofit sites were rated superior in terms of transparency and accessibility, whereas the privately owned sites compared multiple procedures, structures, and outcomes. Neither group of sites explicitly defined complications from procedures.

Majority of Americans unsatisfied with healthcare

According to the *2006 National Healthcare Quality Report* conducted by the Agency for Healthcare Research and Quality, less than half of Americans say they receive great healthcare when visiting a doctor's office or medical clinic. The study, which was reviewed by the *Los Angeles Times*, was based on a poll of 21,000 adults aged 18 or older who had visited their doctor or a medical clinic within a year of the survey. Just 48% of the respondents rated their care as high quality. On a scale of 0–10, with 10 as the best, the most satisfied group was whites, 49% of whom rated their care as a 9 or 10.

The most pleased group over all was the 65 and older age group; 59% of this group rated their care as a 9 or 10. The most dissatisfied group was Asians, of whom 31% rated their care as a 9 or 10. They were followed by American Indians and Alaska natives, at 37%, the uninsured, at 39%, and Hispanics, at 43%. The privately insured and black demographic tied at 46% and rated care as a 9 or 10.

Overall, 46% of males and 49% of females rated their care as a 9 or 10.

Poor bedside manners lead to poor communication with patients

A study released by researchers at McGill University in Montreal reveals that doctors who perform poorly on the communications portion of their clinical exams have a high likelihood of butting heads with patients in the future.

According to *Time*, the researchers followed up in 2005 with all 3,424 physicians who had taken the Medical Council of Canada clinical skills examination from 1993 to 1996 and were then licensed to practice in Canada.

The exam requires doctors to simulate doctor-patient interaction with actors posing as patients, and the doctors are graded on taking patient histories, diagnosing ailments, managing treatment, and interacting with patients.

Researchers discovered a correlation between the test scores and the number of patient complaints in the doctors' first year of practice.

In total, 3,424 physicians had 1,116 complaints, 696 of which were deemed legitimate after investigation.

Doctors who scored in the lowest 25% of the test had 70% more complaints than those who scored in the top 25%.

Poor communicators received more than four complaints per 100, whereas superior communicators had more than two complaints per 100.

The way in which a doctor told the patient of the ailment was the strongest determining factor of the nature of the patient's complaint.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Strategic notes

Ohio billboards turning heads

Marketing and PR specialists at Akron (OH) General Medical Center were looking for a way to grab the public's attention. Based on the surprised reactions of some motorists, they got it. According to Mary Brackle, director of marketing at the hospital, a new advertising campaign featuring blank billboards with two-dimensional figures ran for two weeks before the public and employees were clued in.

After two weeks and six phone calls to Clear Channel Outdoor, police, and rescue crews, the hospital added a giant picture of a pillow under one billboard that said, "In case of emergency. Akron General." The campaign is the result of collaboration between Akron General and Milwaukee-based BVK, a PR firm that has run advertising campaigns for 220 other hospitals and healthcare clients.

The campaign was a well-kept secret even within the hospital, which launched it to promote emergency services and wellness programs. Those who called Clear Channel Outdoor, the owners of the billboards, were not told who was responsible.

According to TNS Media Intelligence, ad spending by hospitals, clinics, and medical centers across the country has increased from more than $709 million in 2002 to $1.2 billion in 2006. Akron General is spending about $1.5 million this year on advertising.

Healthcare direct marketing goes online

Both the business-to-business and consumer segments of healthcare marketing have seen a rise in e-mail marketing. Concern about return on investment, coupled with online information-seeking, is leading more healthcare professionals to make the switch to e-mail marketing.

According to *DM News*, medical marketers—specifically pharmaceutical marketers—are making extensive use of e-mail to persuade physicians to prescribe their products. E-detailing is replacing the face-to-face interaction between sales representatives and physicians due to the high number of representatives and the scarce amount of free time available to doctors. E-mails are growing in popularity as virtual sales calls.

The AMA Physicians List allows pharmaceutical companies to specifically reach doctors. Although the list doesn't have physicians' e-mail addresses, some list managers use non-AMA e-mail addresses to broadcast messages. Many of the managers who generate broadcasts can custom create mailing lists based on specialty, age, gender, location, and prescribing characteristics.

Terry Nugent of Medical Marketing Services, Inc., in Wood Dale, IL, says responses are the key metric, not the volume of messages sent. The best messages are easily scanned in the preview pane and should be tested against spam filters due to the saturation of consumer spam from unlawful vendors of prescription drugs.

***HSM* Subscriber Services Coupon**

❑ Start my subscription to **HSM** immediately.

Options:	No. of issues	Cost	Shipping	Total
❑ Print & Electronic 1 yr	12 issues	$289 (HCSMNPE)	$24.00	
❑ Print & Electronic 2 yr	24 issues	$520 (HCSMNPE)	$48.00	
		Sales tax (see tax information below)*		
		Grand total		

Order online at *www.hcmarketplace.com.* Be sure to enter source code N0001 at checkout!

For discount bulk rates, call toll-free at 888/209-6554.

***Tax Information**
Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV. State that taxes products only: AZ. Please include $27.00 for shipping to AK, HI, or PR.

Your source code: N0001

Name

Title

Organization

Address

City State ZIP

Phone Fax

E-mail address
(Required for electronic subscriptions)

❑ Payment enclosed. ❑ Please bill me.

❑ Please bill my organization using PO #

❑ Charge my: ❑ AmEx ❑ MasterCard ❑ VISA

Signature
(Required for authorization)

Card # Expires
*(Your credit card bill will reflect a charge to HCPro, the publisher of **HSM**.)*

Mail to:* HCPro,** P.O. Box 1168, Marblehead, MA 01945 ***Tel: 800/650-6787 ***Fax:*** 800/639-8511 ***E-mail:*** *customerservice@hcpro.com* ***Web:*** *www.hcmarketplace.com*

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Strategic notes

Hospital facelifts help patients, families

Efforts to improve the experience of both the patient and his or her family have begun in earnest as construction continues at SSM St. Clare Health Center in St. Louis, mirroring a nationwide trend. The ground-breaking ceremony for the hospital was in June 2006, and although the facility is not yet completed, plans are under way to improve both safety and recovery time.

According to the *St. Louis Post-Dispatch*, the changes will range from installing chair rails that increase mobility to more complicated add-ons. At the recently completed Progress West Hospital in O'Fallon, MO, BJC Healthcare is using kiosks to help admit patients. The 158 rooms at St. Clare will be private and feature family zones with bench seating, a table, and a chair. The design of the 370-square-foot rooms encourages families to stay with patients.

All of the private rooms allow the patient to control lighting, sound, and temperature, and many can be transformed to care for seriously ill patients.

Paul Strohm, senior vice president and healthcare director at the St. Louis–based architecture firm Hellmuth, Obata & Kassabaum, Inc., says renovations mean that hospitals and architects must "rethink care delivery at its core" when building a facility. Strohm and his team are designing a Milwaukee, WI, hospital for Ascension Health of Edmundson. As a compromise between the nurses, who want computers nearby or in patients' rooms, and patients, who prefer traditional nurses' stations, Ascension has created computer workstations for the nurses near, but not in, patients' rooms.

Chicago hospital consolidates women's care

Northwestern Memorial HealthCare's $500 million Prentice Women's Hospital in Chicago is indicative of a growing trend—providing medical care at one location for every stage of a woman's life, the *Chicago Tribune* reports.

The new facility, which opened last month, will provide gynecologic, breast oncology, and plastic surgery medical procedures, in addition to providing maternity care for more than 10,000 women and infants annually. Consolidation of medical services is becoming more common as a response to rising medical care service costs.

Prentice patients and their families provided input during the designing and construction of the new 17-story facility, which will feature 86 neonatal intensive care beds compared to the 46 existing beds. Neonatal units now have sliding doors so parents of premature twins can more easily visit the adjoining rooms. There is also a 124-ft walking track for expectant mothers who may be experiencing false labor. Along the side of the track are couches and a television that displays educational programs about maternity.

Other facilities in Chicago are expanding and addressing space concerns. Rush University Medical Center and the University of Chicago Medical Center are building replacement hospitals for adults. Children's Memorial Hospital is relocating in 2012 to be closer to Prentice.

Hospital features self-check-in kiosks for ER department

In an effort to combat long waits in the emergency department (ED), Parkland Memorial Hospital in Texas has introduced kiosks where patients can check in. More serious cases, such as a gunshot victim or a patient suffering a heart attack, will be rushed to emergency care, but the system is designed to shorten the wait time to register and explain symptoms. The ED handles nearly 300 cases a day.

Like terminals in airports and hotels, computer kiosks are a growing trend in hospitals across the country. Newark (NJ) Beth Israel Medical Center is planning to install kiosks, and Satellite Med, an urgent care center in Tennessee, has been using kiosks for more than a year. Prior to the kiosks, Parkland nurses checked in patients and took vital signs as lines for the ER grew. Now, by inputting their name, age, and other personal information, patients can choose from a list of ailments.

Once the ailments are entered using a touch screen, the information is sent to the nurses' station. Patients who enter chest pains, stroke symptoms, or other urgent complaints are given priority. At Parkland Memorial Hospital, patients spend an average of eight minutes entering information.

continued on p. 16

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.

© 2007 HCPro, Inc.

Strategic notes

continued from p. 15

Virtual welcome center lets patients preview hospital

A Tennessee hospital has found a new way to let patients and their families tour the grounds before they have been admitted to the facility. According to a press release issued by the hospital, Methodist Le Bonheur Healthcare has launched a virtual welcome center that provides a visual tour of Methodist University Hospital in Memphis, TN.

In addition to letting visitors schedule appointments with a doctor, obtain a referral, or ask a question about services, the virtual welcome center also features video tours of the hospital. The virtual welcome center is an extension of the Methodist University Hospital surgical Webcasting program, which has received 250,000 hits. An additional 131,000 viewers have logged on to see a live or archived event.

Jill Fazakerly, director of marketing for Methodist Healthcare, said the Virtual Welcome Center provides unparalleled educational opportunities for medical staff, patients, and families. The site includes PDF downloads of a campus map, a map of the surrounding area, and locations of hotels, restaurants, and gas stations.

Hospital recovers by boosting patient satisfaction

Thanks largely to new patient satisfaction strategies, a hospital went from the brink of bankruptcy to becoming a major player in the same league as some of the country's big name hospitals, *The Kansas City Star* reports.

Prior to the improvements, low patient satisfaction scores left the University of Kansas Hospital in the lowest 5% of hospitals in the country. One-third of the staff was leaving annually, and auditors said in 1996 that the hospital would be losing $20 million annually by 2000.

From 1993 to 1998, just $33 million was spent on capital improvements; in the past two years, more than $200 million has been spent, and the results are clear.

Among the improvements are an automated laboratory for blood work, rapid response team crash carts and defibrillators, a pharmacy where a robot dispenses medicine, and a medication reconciliation program that allows doctors to check a patient's medication history by cross-referencing local pharmacies.

Since the improvements, staff retention has increased, and patient deaths, prescription errors, and infections have decreased. Patient satisfaction surveys place the University of Kansas Hospital in the top 10% of hospitals nationwide. Customer satisfaction continues to be a mandatory course for hospital staff, and so far more than 8,000 employees have taken the eight-hour course.

Questions? Comments? Ideas?

Contact Managing Editor
Maureen O. Larkin

Telephone: **781/639-1872, Ext. 3913**

E-mail: ***mlarkin@hcpro.com***

Editorial Board

Group Publisher: **Matt Cann**
Executive Editor: **Amy Anthony**
Managing Editor: **Maureen O. Larkin,**
mlarkin@hcpro.com

DON ARNWINE, President
Arnwine & Associates, Irving, TX

KARL G. BARTSCHT, President
Superior Consultant Co., Inc., Management Consulting Division, Ann Arbor, MI

DAVID BURIK, President
Tiber Group, Chicago, IL

DEAN C. CODDINGTON, Senior Consultant
McManis Consulting, Greenwood Village, CO

WILLIAM GALVAGNI, President
Galvagni Strategy Group, Louisville, KY

JULIANNE R. HOWELL, PhD, Director
Health Sciences Planning, Univ. of California–San Diego, San Diego, CA

SCOTT MACSTRAVIC, PhD, Principal
Demand Engineering, Golden, CO

MARY HOUSTON MCLENDON, President and CEO
The Center for Health Care Planning, Nashville, TN

DONALD P. POTTER, President
Southeast Michigan Health and Hospital Council, Southfield, MI

LEN B. PRESLAR JR., President
North Carolina Baptist Hospital, Winston-Salem, NC

IRA H. SCHLEZINGER, Managing Director
Strategic Services, Integris Health, Oklahoma City, OK

JAMES N. WOLF, ScD, CEO
District One Hospital, Faribault, MN

Healthcare Strategic Management (ISSN 0742-1478) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: $289/year. • Postmaster: send address changes to **Healthcare Strategic Management**, P.O. Box 1168, Marblehead, MA 01945. • Copyright 2007 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call our Customer Service Department at 800/650-6787, fax 800/639-8511, or e-mail: *customerservice@hcpro.com*. • Visit our Web site at *www.hcpro.com* or *www.healthleadersmedia.com*. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of **HSM.** Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. **Healthcare Strategic Management** is indexed in Hospital and Health Administration Index, American Hospital Association.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at *www.copyright.com* or 978/750-8400.