

Editorial

The international agenda on health is definitely driven by the non communicable diseases and the ageing population topics.

Rather than focusing on just non communicable diseases it is preferable to consider the perspective of chronic conditions and the special challenge of multi-chronic conditions as OECD has been doing.

Adoption of such a view would allow the focus of discussion to be on the major constraints relating to payment systems and the different funding organizations. Although there is a large diversity of systems, none are adapted for paying continuity of care and for allowing adoption of a more holistic approach to treatment of conditions, especially in current situations where social factors are becoming major drivers in care needs.

The healthcare industry needs a revolution to change organizations still mostly based on specific diseases or organs. They have to move toward organizations better aligned with major chronic conditions and fully patient-centered.

Education of health professionals and trends for hyper specialization are other challenges to face, in order to improve efficiency in healthcare provided to patients with multi chronic condition.

Last but not least, empowerment of patients to be better able to face their condition is also a key to future developments. Are health care organizations doing well in this area?

To better understand the nature of challenges health care organizations are facing IHF has launched a survey among its members which will give a better grasp of their peculiarities and commonalities for which they can use IHF as hub to exchange ideas on difficulties and solutions.

IHF News

IHF Events

Iran

The Second International Congress on **The Role of Leadership and Human Resources for Hospital Accreditation**, had been successfully held 8th and 9th July 2012, Tehran, Iran

This Congress was organized by Hospital Management Research Center (HMRC) (<http://hmrc.ir>) and Tehran University of Medical Sciences (TUMS) (<http://tums.ac.ir>) with the support of International Hospital Federation (IHF) (<http://www.ihf-fih.org/>) and MOHEB Medical Institute (MMI) (www.mohebmed.com).

More than 940 participants had registered prior to the commencement of the Congress this figure reached above 1,100 in the first day of Congress. Participants had mostly been CEO and Directors of Hospitals, Managers and Supervisors of Hospitals in addition to Medical Doctors, Nurses, Paramedical Professional who are in leadership positions, and also there were several leaders from Iran's Health Ministry?

Click to view full Congress report and presentations **(NB: Some presentations are in Persian)**.

South Africa - The 3rd IHF Hospital and Healthcare Association Leadership Summit

The **3rd IHF Hospital and Healthcare Association Leadership Summit**, the first major official IHF event in sub-Saharan Africa, was held **5-6 June 2012 in Sun City, South Africa**. The event was jointly hosted with the Department of Health of South Africa

The event was jointly hosted with the Department of Health of South Africa on the topics of Leadership and Management; Performance based financing of hospitals; Error reduction to enhance patient safety; Current trends on public private mix in

health service delivery. A pre-Summit programme hosted by the Department of Health (DoH) addressed the topics within the African context. This was followed by a joint IHF/DoH Forum, open to IHF and non-IHF Members as well as local participants, in which the Summit topics were addressed within the international context. The plenary sessions and roundtable debates of the IHF members only Forum, centered also on the topics of Medical Tourism & Leadership Competencies. The event was attended by 130 participants from 22 countries. The IHF by this tool is able to fulfill its mandate in serving as a platform for knowledge sharing and discussion.

Click to view the Summit Proceedings and presentations.

WHO Round Up

Infection prevention and control in health-care facilities

As the centres where the most serious illnesses are treated, hospitals are unfortunately also where antibiotic-resistant infections are particularly likely to develop and spread. Infections acquired in hospitals and other health-care facilities (nosocomial infections) caused by resistant bacteria exert a heavy toll in terms of illness and mortality, as well as added direct and indirect costs. The key to limiting the risk lies in the meticulous application of measures for the prevention and control of infection.

Summary

The hospital environment favours the emergence and spread of resistant bacteria. In Europe, the death toll from health care-associated infections (HAI) caused by multidrug-resistant bacteria is estimated to exceed 25 000 per year and the death rate may be higher in other parts of the world. In addition to human suffering, the consequences of AMR also result in higher direct and indirect financial costs.

Infection prevention and control (IPC) measures are designed to prevent the spread of pathogens, including those with AMR, within and between health-care facilities, and from facilities to the community, and also vice versa. This was emphasized in the 2001 WHO Global Strategy for Containment of Antimicrobial Resistance and in the 2011 World Health Day policy briefs.

Interventions to bring about system change in individual health-care facilities involve organizational structures, human resources, guidelines, protocols and practices, monitoring and evaluation, infrastructure, and linking to public health services. In addition to the standard IPC measures, there are specific recommendations concerning AMR pathogens.

Many facilities and countries have progressed well in implementing recommendations on IPC and there have also been several welcome innovations recently in the field of IPC, as outlined in this chapter. WHO has led and coordinated the development of guidance on core components of IPC, based on evidence-based principles. However, there are considerable differences within and between countries in the extent to which IPC measures are implemented.

Health-care facilities in some countries lack even the basic elements of IPC. Situation analyses at national and facility levels would help to define the current status, to set realistic goals for the local context, and to develop strategies for progressive improvement.

The gaps and challenges include: lack of data related to HAI and inadequate laboratory capacity in many parts of the world; lack of uniform standards, data collection methods and definitions; insufficient information on the effectiveness of specific interventions and the resources needed for effective and sustained implementation. This chapter examines the situation and options for action to improve it.

Read the whole article in http://whqlibdoc.who.int/publications/2012/9789241503181_eng.pdf page 63

World Malaria Report 2011

The **World Malaria Report 2011** summarizes information received from 106 malaria-endemic countries and a range of other sources.

It analyses prevention and control measures according to a comprehensive set of indicators, and highlights continued progress towards global malaria targets. This year's report builds primarily on data received from countries for the year 2010. The report shows clear progress in the fight against malaria and a decline in estimated malaria cases and deaths. For the first time, the report contains individual profiles for 99 countries with ongoing malaria transmission.

You can obtain the full report at this address:

Estimating the cost of new public health legislation

Article written by Nick Wilson et al., in WHO Bulletin Volume 90, Number 7, July 2012, page 532

Objective: to develop a new method for estimating the cost to governments of enacting public health legislation

Methods

We adopted a central government perspective in estimating costs. The parliamentary cost of legislative acts and regulations in New Zealand was calculated from the proportion of parliamentary time devoted to law-making (i.e. sitting days in the debating chamber), and the cost of associated policy advice from government agencies was calculated from the proportion of documented policy issues related to law-making. The relative costs of acts and regulations were estimated from the number of pages in the legislation.

Findings

We estimated that, between 1999 and 2010, 26.7% of parliamentary resources and 16.7% of policy advice from government agencies were devoted to generating new laws in New Zealand. The mean cost of an act was 2.6 million United States dollars (US\$; 95% uncertainty interval, UI: 1.5 to 4.4 million) and the mean cost of a regulation was US\$ 382 000 (95% UI: 221 000 to 665 000). For comparison, the average cost of a bill enacted by the 50 state governments in the United States of America between 2008 and 2009 was US\$ 980 000.

Conclusion

We were able to estimate the cost of new legislation in New Zealand. Our method for estimating this cost seemed to capture the main government costs involved and appears to be generally applicable to other developed countries. Ideally such costs should be included in economic evaluations of public health interventions that involve new legislation.

The full paper is available at <http://www.who.int/bulletin/volumes/90/7/11-097584/en/index.html>

From International Organizations The Economics of Public Health Care Reform in Advanced and Emerging Economies

The International Monetary Fund, Washington D.C. 2012.

Editors, Benedict Clements, David Coady, and Sanjeev Gupta.

The mandate of the International Monetary Fund is primarily focused on macroeconomic stability. While recognizing that the issue of health care reform has much broader implications, in this volume we look at health care reform through the lens of our mandate, focusing primarily on macroeconomic stability and of special importance to us in the IMF's Fiscal Affairs Department on fiscal stability.

You can download the full article at this address: <http://www.imf.org/external/pubs/ft/books/2012/health/healthcare.pdf>

Hospitals and Health Services Worldwide News Europe

Grenoble University Hospital: a new design of the surgical unit

A large operating room grouping several tables: this is the configuration chosen by the Grenoble University Hospital for his "operating hall."

The south surgical unit of the hospital was completely modified with the creation of an open space of 180 m² with 4 contiguous operating rooms (or "cells") of 3.60 m x 3.60 m each. **"An appropriate size to proper functioning of an operating hall"** for Anne Dard-Levieux, executive at the CHU.

Dimensions of health care system quality in Finland

This study was written by Jenni Pääkkönen and Timo Seppälä from the Government Institute for Economic Research (VATT), Helsinki 2012.

The main task of a public health care system is to maintain and yield health among the citizens. However, government budgets are tight and the increase in health care expenses together with aging does not help to consolidate the budgets. Decision makers may be able to minimize the increase in health care expenses by allocating resources efficiently. However, policies are not alike: some cost-saving policies may harm the quality of care, while other policies may leave quality intact. To evaluate the influence of cost-savings on quality, one needs first a measurement of quality, and second, the relationship between costs and quality should be verified.

The full study is available in http://www.vatt.fi/file/vatt_publication_pdf/wp31.pdf

What influences national and foreign physicians' geographic distribution? An analysis of medical doctors' residence location in Portugal

Article written by Giuliano Russo, Paulo Ferrinho, Bruno De Sousa and Cláudia Conceição, published in **Human Resources for Health**, July 2012

Background:

The debate over physicians' geographical distribution has attracted the attention of the economic and public health literature over the last forty years. Nonetheless, it is still to date unclear what influences physicians' location, and whether foreign physicians contribute to fill the geographical gaps left by national doctors in any given country.

The present research sets out to investigate the current distribution of national and international physicians in Portugal, with the objective to understand its determinants and provide an evidence base for policy makers to identify policies to influence it.

Methods

A cross-sectional study of physicians currently registered in Portugal was conducted to describe the population and explore the association of physician residence patterns with relevant personal and municipality characteristics. Data from the Portuguese Medical Council on physicians' residence and characteristics were analysed, as well as data from the National Institute of Statistics on municipalities' population, living standards and health care network. Descriptive statistics, chi-square tests, negative binomial and logistic regression modelling were applied to determine: (a) municipality characteristics predicting Portuguese and International physicians' geographical distribution, and; (b) doctors' characteristics that could increase the odds of residing outside the country's metropolitan areas.

Results

There were 39,473 physicians in Portugal in 2008, 51.1% of whom male, and 40.2% between 41 and 55 years of age. They were predominantly Portuguese (90.5%), with Spanish, Brazilian and African nationalities also represented. Population, Population's Purchasing Power, Nurses per capita and Municipality Development Index (MDI) were the municipality characteristics displaying the strongest association with national physicians' location. For foreign physicians, the MDI was not statistically significant, while municipalities' foreign population applying for residence appeared to be an additional positive factor in their location decisions. In general, being foreigner and male resulted to be the physician characteristics increasing the odds of residing outside the metropolitan areas. However, among the internationals, older doctors were more likely to reside outside metropolitan areas. Being Spanish or Brazilian (but not of African origin) was found to increase the odds of being based outside the Lisbon and Oporto metropolitan areas.

Conclusions

The present study showed the relevance of studying one country's physician population to understand the factors driving national and international doctors' location decisions. A more nuanced understanding of national and foreign doctors' location appears to be needed to design more effective policies to reduce the imbalance of medical services across geographical areas.

Download the full article in pdf

Africa

ICTs to transform health in Africa: Can we scale up governance and accountability?

Submitted by Meera Shekar.

Start-up eHealth innovations are popping up all over Africa, providing a glimpse of how ICTs (Information Communication Technology) can transform the delivery and governance of health services in the region.

Many of these pilots show promise, but their rapid growth also poses challenges: At an eHealth conference held in Nairobi in May and co-organized by the World Bank, health professionals and development partners discussed how to identify the best of these evolving tools and bring them to scale.

Follow this link to view the full article

http://blogs.worldbank.org/health/icts-to-transform-health-in-africa-can-we-scale-up-governance-and-accountability?cid=ISG_E_WBWeeklyUpdate_NL

The future of healthcare in Africa

A report from the Economist Intelligence Unit.

Healthcare demands in Africa are changing. Ensuring access to clean water and sanitation, battling ongoing communicable diseases and stemming the tide of preventable deaths still dominate the healthcare agenda in many countries. However, the incidence of chronic disease is rising fast, creating a new matrix of challenges for Africa's healthcare workers, policy makers and donors.

A growing urban middle class is willing to pay for better treatment. This has opened the door to the private sector, which is starting to play a new role, often working in partnership with donors and governments to provide better healthcare facilities and increased access to medicine at an affordable price.

For the vast majority of Africans still unable to pay for health provision, new models of care are being designed, as governments begin to acknowledge the importance of preventive methods over curative action. This, in turn, is empowering communities to make their own healthcare decisions. At the same time, some countries are experimenting with different forms of universal health provision.

Africa's healthcare systems are at a turning point. The reforms that governments undertake over the next decade will be crucial to cutting mortality rates and improving health outcomes in the continent. The Economist Intelligence Unit has undertaken this research to focus on how African healthcare systems might develop between now and 2022. It looks at both current challenges and promising reforms. The five scenarios that have emerged from this research reflect these trends, and are intended to show the possible consequences of decisions being taken by healthcare's stakeholders today.

Download the full report

Americas

PAHO launches Primary Health Care Collaborative Network to promote cooperation and exchange of experiences

The Primary Health Care Collaborative Network, an electronic forum where people can share and discuss experiences, practices, and lessons learned in this field, was launched 1 August at the International Seminar on Primary Health Care organized by the Ministry of Health of Brazil in Rio de Janeiro.

The Collaborative Network is intended to strengthen primary health care as a strategy to transform health systems in the Americas through an e-forum that uses information technologies and communication to bring knowledge to action and action to knowledge.

This is an initiative of the Pan American Health Organization/World Health Organization (PAHO/WHO), the Ministry of Health of Brazil, and the Andalusian School of Public Health, with support from the Spanish Agency for International Development Cooperation (AECID) and the Canadian International Development Agency (CIDA).

PAHO/WHO seeks to connect this collaborative network with other initiatives and to coordinate with institutions and people interested in joining the network. It also aims to bring together and invite researchers and managers to contribute to the collaborative network, either individually or through the institutions to which they belong.

The objectives of this initiative are to build bridges among the various stakeholders involved in processes for implementing change in health systems and services; to socially and politically validate the primary health care strategy (PHC) as the cornerstone for development of health systems; to strengthen PHC as central to technical cooperation and the integration of projects and themes within PAHO/WHO and in countries; to disseminate the most effective work processes in PHC; and to share knowledge in this area.

Virtual communities of practice (COP) related to primary health care will drive the process. The COP platform is open to the public, affording a virtual space where people can share and discuss experiences, practices, and lessons learned in this field.

Experts from the following countries collaborated on the initial design of the initiative: Brazil, Canada, Colombia, Chile, Spain, Peru, and Paraguay, among others. Technical discussions with experts, managers, and consultants of PAHO/WHO in the Americas and Spain were held during the implementation process.

PAHO, which celebrates its 110th anniversary this year, is the oldest public health organization in the world. It works with its member countries to improve the health and the quality of life of the people of the Americas. It also serves as the Regional Office for the Americas of WHO.

Follow this link to visit the forum: <http://ops.opimec.org/>

Wireless devices incite 'Medical Spring'

Article written by Douglas Page. **First appeared in the June 2012 issue of H&HN magazine.**

A new breed of technology is making diagnosis and treatment more targeted, effective and efficient.

How can hospitals harness all that potential?

An army of novel implantable, ingestible wireless medical devices is mobilizing to march medicine into the future.

These technologies show potential to improve patient care, reduce medical errors and lower costs. One example: Researchers at Brigham and Women's Hospital, Boston, are providing a better endoscopy camera capsule. This one is steerable, a big improvement on current capsule endoscopy technologies, which merely tumble uncontrollably through the digestive tract. The BWH design allows radiologists to guide the device during MRI scans and aim the onboard camera to obtain real-time images of specific areas of interest. Ultimately, that may mean less invasive and less costly examinations of digestive tract disorders, particularly in the hard-to-reach small intestine.

The BWH device has a unique propulsion system. "We use both static and radio frequency magnetic fields available in MRIs to generate capsule propulsion," says Nobuhiko Hata, an associate professor in the BWH radiology department.

Another example: A new device wirelessly transmits data from sites of recent orthopedic surgeries. This one, from Rensselaer Polytechnic Institute, Troy, N.Y., promises cost-effective and less invasive post-surgery monitoring.

Usually, surgeons rely on imaging studies to assess orthopedic recovery. Now, once implanted near the surgical site, RPI's sensor transmits data about load, strain, pressure and temperature.

One more: A device developed at the Massachusetts Institute of Technology, now licensed to a Waltham, Mass., company called MicroCHIPS, enables personalized drug delivery. "Each implant can contain multiple drugs that are released at precise times, thereby relieving patients of remembering to take medications," says MicroCHIPS President and Chief Operating Officer Robert Farra. The result, Farra says: better compliance, better outcomes and lower costs.

Read the full article at:

http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/06JUN2012/0612HHN_FEA_Wireless&domain=HHNMAG

The Sensitivity of Adverse Event Cost Estimates to Diagnostic Coding Error

Article written by Gavin Wardle et al., in HSR, Volume 47, Number 3, June 2012, Part I.

Objective: To examine the impact of diagnostic coding error on estimates of hospital costs attributable to adverse events.

Data Source: Original and reabstracted medical records of 9,670 complex medical and surgical admissions at 11 hospital corporations in Ontario from 2002 to 2004. Patient specific costs, not including physician payments, were retrieved from the Ontario Case Costing Initiative database.

Study Design: Adverse events were identified among the original and reabstracted records using ICD10-CA (Canadian adaptation of ICD10) codes flagged as postadmission complications. Propensity score matching and multivariate regression analysis were used to estimate the cost of the adverse events and to determine the sensitivity of cost estimates to diagnostic coding error.

Principal Findings: Estimates of the cost of the adverse events ranged from \$16,008 (metabolic derangement) to \$30,176 (upper gastrointestinal bleeding). Coding errors caused the total cost attributable to the adverse events to be underestimated by 16 percent. The impact of coding error on adverse event cost estimates was highly variable at the organizational level.

Conclusions: Estimates of adverse event costs are highly sensitive to coding error. Adverse event costs may be significantly underestimated if the likelihood of error is ignored.

The full document is available in <http://www.hsr.org/hsr/abstract.jsp?aid=47884936758>

What Is the Best Way to Estimate Hospital Quality Outcomes? A Simulation Approach

Article written by Andrew Ryan, James Burgess, Robert Strawderman and Justin Dimick in HSR, Volume 47, Number 4, August 2012.

Objective: To test the accuracy of alternative estimators of hospital mortality quality using a Monte Carlo simulation experiment.

Data Source. Data are simulated to create a mission-level analytic dataset. The simulated data are validated by comparing distributional parameters (e.g., mean and standard deviation of 30-day mortality rate, hospital sample size) with the same parameters observed in Medicare data for acute myocardial infarction (AMI) in patient admissions.

Study Design. We perform a Monte Carlo simulation experiment in which true quality is known to test the accuracy of the Observed-over-Expected estimator, the Risk Standardized Mortality Rate (RSMR), the Dimick and Staiger (DS) estimator, the Hierarchical Poisson estimator, and the Moving Average estimator using hospital 30-day mortality for AMI as the outcome. Estimator accuracy is evaluated for all hospitals and for small, medium, and large hospitals.

Data Extraction Methods. Data are simulated.

Principal Findings. Significant and substantial variation is observed in the accuracy of the tested outcome estimators. The DS estimator is the most accurate for all hospitals and for small hospitals using both accuracy criteria (root mean squared error and proportion of hospitals correctly classified into quintiles).

Conclusions. The mortality estimator currently in use by Medicare for public quality reporting, the RSMR, has been shown to be less accurate than the DS estimator, although the magnitude of the difference is not large. Pending testing and validation of our findings using current hospital data, CMS should reconsider the decision to publicly report mortality rates using the RSMR.

Read the full article <http://www.hsr.org/hsr/abstract.jsp?aid=4727107273>

Using Electronic Health Records to Improve Quality and Efficiency: The Experiences of Leading Hospitals

Article written by Sharon Silow-Carroll, Jennifer N. Edwards, and Diana Rodin and published in **Commonwealth Fund pub.** 1608 Vol. 17.

Abstract: An examination of nine hospitals that recently implemented a comprehensive electronic health record (EHR) system finds that clinical and administrative leaders built EHR adoption into their strategic plans to integrate inpatient and outpatient care and provide a continuum of coordinated services.

Successful implementation depended on: strong leadership, full involvement of clinical staff in design and implementation, mandatory staff training, and strict adherence to timeline and budget. The EHR systems facilitate patient safety and quality improvement through: use of checklists, alerts, and predictive tools; embedded clinical guidelines that promote standardized, evidence-based practices; electronic prescribing and test-ordering that reduces errors and redundancy; and discrete datafields that foster use of performance dashboards and compliance reports. Faster, more accurate communication and streamlined processes have led to improved patient flow, fewer duplicative tests, faster responses to patient inquiries, redeployment of transcription and claims staff, more complete capture of charges, and federal incentive payments.

Click to download the full article

International Events

Hospital Management Asia 2012

September 13-14, 2012

Hanoi, Vietnam

For more information: <http://hospitalmanagementasia.com/>

American Nurses Credentialing Center: ANCC National Magnet Conference

October 10-12, 2012

Los Angeles Convention Center, California
USA

For more information: <http://www.anccmagnetconference.org/>

Medical Group Management Association Annual Conference

October 21-24, 2012

Convention Center, Grand Hyatt

San Antonio, TX

In 2011, the Medical Group Management Association (MGMA) and its standard-setting body, the American College of Medical Practice Executives (ACMPE), voted to merge to form a new association, MGMA-ACMPE. MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices with 22,500 members who lead 13,600 organizations nationwide. Its diverse membership comprises administrators, CEOs, physicians in management, board members, office managers and many other management professionals. They work in medical practices and ambulatory care organizations of all sizes and types.

For more information: <http://www.mgma.com/mgma12/>

Healthcare Supply Chain Association: 2012 International Expo

October 22-24, 2012

JW Marriott Grande Lakes

Orlando, Florida

For more information: http://www.supplychainassociation.org/events/event_details.asp?id=167432

4th International Hospital Congress

November 7-9, 2012

Lisbon, Portugal

For more information: <http://www.apdh.pt/node/389>

UHC Annual Conference 2012

September 13-14, 2012

JW Marriott Grande Lakes

Orlando, Florida

website: www.uhc.edu/UHC2012.htm

Healthcare Information and Management Systems Society's Annual Conference and Exhibition

March 3-7, 2013

Convention Center

New Orleans, LA

USA

The Healthcare Information and Management Systems Society (HIMSS) is a membership organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. HIMSS represents more than 44,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS frames and leads healthcare public policy and industry practices through its educational, professional development, and advocacy initiatives designed to promote information and management systems' contributions to ensuring quality patient care.

For more information: <http://www.himssconference.org/>

American College of Healthcare Executives: Congress on Healthcare Leadership

March 11-14, 2013

Hilton Chicago & Palmer House Hilton

Chicago, Illinois

USA

The American College of Healthcare Executives (ACHE) is an international professional society of more than 35,000 healthcare executives who lead hospitals, healthcare systems and other healthcare organizations. ACHE is known for its prestigious FACHE® credential, signifying board certification in healthcare management, and its educational programs including the annual Congress on Healthcare Leadership, which draws more than 4,500 participants each year.

For more information: <http://ache.org/Congress>

American Organization of Nurse Executives' Annual Meeting and Exposition

March 19-22, 2013

Convention Center

Denver, Colorado

USA

The American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association, is a national membership organization of over 8,000 nurse leaders who design, facilitate and manage care. AONE provides leadership, professional development, advocacy and research in order to advance nursing practice and patient care, promote nursing leadership excellence and shape healthcare public policy.

American Hospital Association's Annual Meeting

April 28 - May 1, 2013

Hilton Washington
Washington, DC
USA

The American Hospital Association (AHA) leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement with 5,000 institutional members and 40,000 individual members. The AHA Annual Meeting is an educational meeting with a primary focus on national legislative and regulatory issues.

For more information: www.aha.org

Healthcare Financial Management Association's Healthcare Finance Conference

June 16-19, 2013

Orange County Convention Center
Orlando, FL
USA

The Healthcare Financial Management Association (HFMA) is a membership organization for healthcare financial management executives and leaders. HFMA's more than 37,000 members range from CFOs to controllers to accountants and can be found in all areas of the healthcare system, including hospitals, managed care organizations, physician practices, accounting firms, and insurance companies. HFMA helps healthcare finance professionals meet the challenges of the modern healthcare environment by providing education, analysis, and guidance.

American Hospital Association's Leadership Summit

July 27-29, 2013

San Diego Hyatt
San Diego, CA
USA

The American Hospital Association (AHA) leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement with 5,000 institutional members and 40,000 individual members.

The Leadership Summit is an educational meeting which focuses on the organizational characteristics, structures, and processes that lead to a high-performing system of care.

American Nurses Credentialing Center: ANCC National Magnet Conference

October 2-4, 2013

Orlando, Florida
USA

For more information: <http://www.anccmagnetconference.org/>

Medical Group Management Association Annual Conference

October 6-9, 2013

Convention Center, Marriott

San Diego, CA

USA

In 2011, the Medical Group Management Association (MGMA) and its standard-setting body, the American College of Medical Practice Executives (ACMPE), voted to merge to form a new association, MGMA-ACMPE. MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices with 22,500 members who lead 13,600 organizations nationwide. Its diverse membership comprises administrators, CEOs, physicians in management, board members, office managers and many other management professionals. They work in medical practices and ambulatory care organizations of all sizes and types.

Corporate Partners