Building Compassion into the Bottom Line:

The Role of Compassionate Care and Patient Experience in 35 U.S. Hospitals and Health Systems

March 2015

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"At age 40, I was diagnosed with advanced lung cancer. In the months that followed, I was subjected to chemotherapy, radiation, surgery and news of all kind, most of it bad. It has been a harrowing experience for me and for my family. And yet, the ordeal has been punctuated by moments of exquisite compassion. I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness – the simple human touch from my caregivers – have made the unbearable bearable."

- From "A Patient's Story" by Ken Schwartz

the schwartz center
FOR COMPASSIONATE HEALTHCARE

EXECUTIVE SUMMARY

Compassion is not a panacea for what ails the U.S. healthcare system, but it can be the foundation for improving patients' care experiences, patient and caregiver satisfaction, and a hospital's bottom line.

According to interviews with CEOs and senior leaders at 35 U.S. hospitals and hospital-based health systems known for their patient experience improvement initiatives and commitment to compassionate care:

- Organizations that place a high priority on delivering compassionate care benefit from lower staff turnover, higher retention, recruitment of more highly qualified staff, greater patient loyalty and reduced costs from shorter lengths of stay, lower rates of rehospitalization, better health outcomes, and fewer costly procedures.

- Caregivers who are able to express compassion for patients, families and each other experience higher job satisfaction, less stress, and a greater sense of teamwork.

- Patients who are treated compassionately benefit from improved quality of care, better health, fewer medical errors, and a deeper human connection with their caregivers.

Successful organizations understand that employee experience drives patient experience and compassionate care, believe that supporting caregivers is essential to preserving their compassion, and incorporate compassionate care practices into their patient experience initiatives.

These organizations also have other characteristics in common:

- A commitment to involving patients and families in care improvement activities

- Hiring practices and training programs that focus on compassion

- A culture of experimentation, compassionate care champions, and units that model compassion and share their strategies with others

- An emphasis on continuity of care and teamwork

- A willingness to share patient experience data to drive improvement

- A belief that simple tactics can make a difference

According to a [national poll](#), more than 80% of recently hospitalized patients said compassionate care is very important to medical treatment and can make a life-or-death difference. Yet, nearly half of patients surveyed said the U.S. healthcare system lacks compassion, and an almost equal number said that most clinicians do not provide compassionate care.
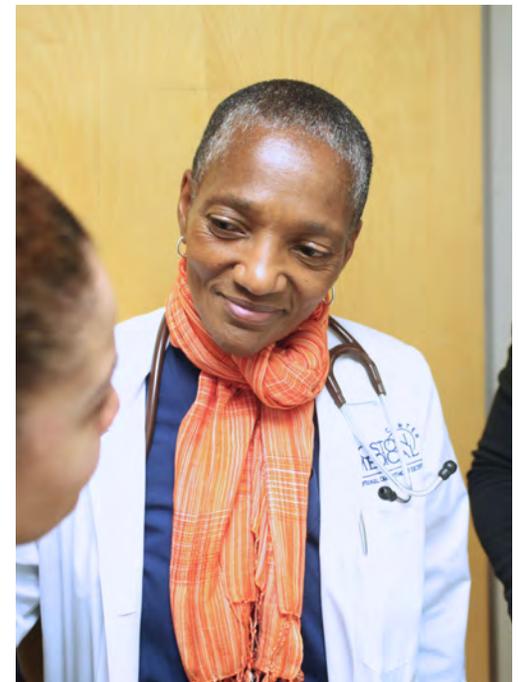
Caregivers witness suffering, trauma and conflict on a daily basis. Their ability to sustain their compassion and provide compassionate care to patients and families rests on both systemic and individual factors. Systemic factors, such as excessive workloads, decreased autonomy, lack of rewards, loss of a sense of community with colleagues, and conflict between organizational and individual values contribute to burnout and erode engagement with their work and sense of purpose. Individual factors that sustain compassion include the capacity to recognize, process and manage the daily challenges of patient care.

In light of alarming rates of burnout among healthcare professionals, hospital and health system leaders are encouraged to consider the systemic and individual factors that degrade caregiver compassion and patient experience and provide the infrastructure, interventions and incentives to elevate both. Successful programs and approaches are detailed in this report.

BACKGROUND

The Schwartz Center for Compassionate Healthcare (SCCH) has been a leading proponent of compassion in healthcare settings since its inception in 1995. Its Schwartz Center Rounds® program, which brings clinicians and other frontline staff together to discuss the challenging emotional and psychosocial issues they face in caring for patients and families, has been adopted by more than 450 healthcare organizations in the U.S., U.K. and Canada.

In looking beyond its primary focus on caregiver support, education and training to the impact compassionate care has on hospitals and health systems, SCCH applied for and received consulting assistance from Community Action Partners (CAP), a volunteer organization of Harvard Business School and Harvard Kennedy School alumni that provides nonprofits with *pro bono* strategic support.

The CAP team, composed of six Harvard Business School and Harvard Kennedy School alumni, conducted telephone interviews with senior healthcare leaders at hospitals and hospital-based health systems across the U.S. In addition, team members visited three hospitals in the Boston area to conduct more extensive interviews with multiple staff members to gain a deeper understanding of compassionate care practices in a safety net, teaching and community hospital. All interviews were conducted between February and June of 2014.

Hospitals and health systems were selected because they were identified on patient experience organization websites as leaders in this area or were recommended by SCCH staff as being particularly progressive in their compassionate care practices and activities.

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An initial list of 100 hospitals and health systems was winnowed down to 45 through a multi-tier review process to achieve a representative sample by type, size and geographic location. An online survey of Schwartz Center Rounds clinician leaders supplemented the telephone and in-person interviews and yielded similar results.

In addition to the three hospitals where more extensive interviews were conducted, 32 hospitals and health systems agreed to participate, selecting at least one senior patient experience leader for the interview. These senior leaders were promised confidentiality so they could freely discuss failures as well as successes. A complete list of hospitals and health systems that participated is included in the Appendix as are bios of the CAP team members who conducted the interviews.

In order to establish a common understanding, CAP team members provided the following SCCH definition:

> **"Compassionate care is an important and frequently overlooked component of patient-centered care. It addresses the emotional and psychosocial aspects of the patient experience and the patient's innate need for human connections and relationships. At its core, it means recognizing the concerns, distress and suffering of patients and their families and taking action to relieve them. It is based on active listening, empathy, strong communication and interpersonal skills, knowledge of the patient as a whole person including his or her life context and perspective, and the ability to work together to relieve distress."**

Everyone who was interviewed accepted this definition, often citing it as the reason "why we do what we do" and the fundamental reason many senior leaders gave for entering the healthcare profession in the first place. As one senior leader said, "When you combine care and empathy and compassion, it makes for the best overall experience for the patient. We can't control what diseases affect people, but we can control the interactions."
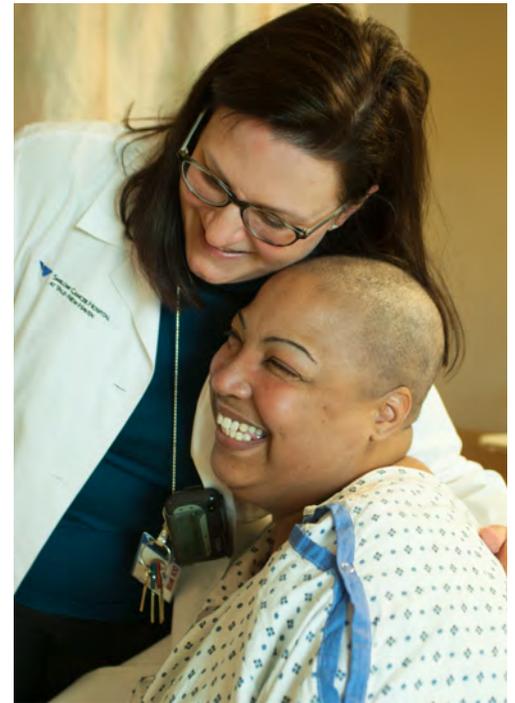
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– A senior leader

KEY FINDINGS

While there is no single source or standard for delivering compassionate care, the interviews revealed a rich landscape of stories, results and ways in which compassionate care is taught, nurtured and supported in hospitals and health systems. The most significant findings are detailed below.

1. EMPLOYEE EXPERIENCE DRIVES PATIENT EXPERIENCE AND COMPASSIONATE CARE.

According to many of those interviewed, the equation is simple: how clinicians and other frontline staff feel about their work drives how patients and families feel about the care they are receiving. As one senior leader said, "We don't want to just provide compassionate care to patients but also promote compassion among employees." Another said, "If staff needs are not addressed, they cannot address patient needs."

The link between employee experience and patient experience makes a strong case for more and better caregiver support programs. All of those interviewed were conscious of caregivers' needs, providing detailed examples of education and training, employee assistance, wellness, mindfulness, and other caregiver support programs. These programs give employees a voice and let them know they are valued. As one senior leader said, "The biggest challenge to employee engagement is the lack of recognition and not listening to their ideas or acting on them." His hospital has daily rounding by the CEO and senior leadership, who spend time with employees and reward acts of kindness and compassion with a movie pass or gift card. Regular town hall meetings provide a venue for awards and for hospital-wide issues to be discussed. One CEO has breakfast every two weeks with a group of 25 employees to hear their concerns.

In order to help staff "stay in the moment" with patients, one hospital has instituted mindfulness training programs and weekly wellness conferences; others have similar programs offered through their integrative medicine units. Another hospital has an expressive therapy center, offering on-site therapy and classes in music, art and dance; yet another has a program that teaches self-care. In still another hospital, the nursing department uses a caring assessment tool that asks, "Do we feel cared for?" The hospital holds nursing leaders accountable for building these caring environments.

"Caring for people in a safety net hospital is a different experience," said one senior leader. "Our patients are people whose lives are chaotic. This is stressful for our employees." This hospital puts its efforts into recognition and team building (whether on a unit or in a service line), since it strengthens the "all-in" environment that is essential to its mission. Another hospital has built a caregiver center.

"We don't want to just provide compassionate care to patients but also promote compassion among employees." – A senior leader

Although used predominantly by family caregivers, it also provides a safe haven for clinicians and other frontline staff, and it is designed to meet their needs as well.

Many of the hospitals interviewed conduct Schwartz Center Rounds to provide a regular opportunity for caregivers to come together to discuss the challenging emotional and psychosocial issues they face in caring for patients and families. The program has been found to enhance compassionate care, improve teamwork, and reduce caregiver stress and isolation. One hospital emergency department has rotating support groups held at physicians' homes. Another has a program that provides emotional support for medical residents on issues related to life and death, and a floor-based program for nurses to refresh and reflect. One hospital was very honest about its relatively new focus on employee experience. While designing a patient-focused trauma support program, a gap analysis revealed that employees were asking, "What about us?" As a result, the hospital redesigned the program to support staff emotionally, recognizing it as the best way to serve both employees and patients.

2. INVOLVING PATIENTS AND FAMILIES IS ESSENTIAL.

Each hospital and health system involves patients and families differently. Programs range from patient and family advisory councils to having patients and family members serve on executive and decision-making teams. According to one senior leader, thinking about families was relatively new to his hospital, saying, "We used to assume that families didn't want to be involved, but we have learned otherwise." Examples include family-centered medical rounds, where doctors meet with patients and then consult with their families outside of patients' rooms; and allowing family members to activate rapid response codes that bring additional medical staff to the bedside immediately. Some practices are simple, such as empowering families with 24/7 visiting hours. There are also more subtle examples of building stronger relationships with families, including sending handwritten notes to patients and families, attending wakes and funerals, and calling families to express sympathy.

Some hospitals and health systems use real-time data from technology systems to measure and remediate patient experience problems as they occur. One provides patients with real-time interactive patient care data to help them feel more connected to their care and help them understand what type of care they should expect. These tools add to the perception of the hospital as caring and compassionate.

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Convening is another popular way of bringing the patient perspective home to staff. One hospital brought together more than 500 staff members (from department chiefs to housekeeping staff), with a former patient at every table to discuss patient care issues. Among the issues discussed was the care of employees and their families - a practical reminder that even staff may become patients some day.

For some hospitals, these programs represent a sea change. "Seven years ago we didn't talk about patients by name, but about 'the one in 5B,'" said one senior leader. This kind of culture change requires multiple and dramatic educational and training efforts at all levels of the organization and over a long period of time, he said. The hospital also looked internally to its palliative care unit, which "opened everyone's eyes to what healthcare could be." Also of note are the hospitals and health systems that have created programs to meet the needs of specific demographic populations. An urban teaching hospital that serves a large Southeast Asian population, for example, has "cultural navigators" to help staff and patients bridge communication and cultural gaps.

A number of hospitals reported using patient stories – both the stories themselves and the act of collecting them – as a way to help caregivers better relate to patients. One senior leader said that, typically, staff would look at a patient's chart, review clinical information, and move on. Now, there is personal information in the chart, such as: "This 45-year-old father of three girls is a plumber who has season tickets to the Red Sox." Another hospital trains volunteers to write short stories about patients' lives that become part of the medical record for the care team.

3. HIRING AND TRAINING ARE CRITICALLY IMPORTANT.

Most hospitals and health systems cited compassion as a make-or-break hiring criterion. Senior leaders at safety net hospitals said they tend to attract compassionate employees naturally, since compassion is "why we choose to do what we do." Others specifically recruit for compassion. One hospital invests in talent management to enable "hiring for attitude" and uses a talent assessment tool to help define the qualities of a compassionate caregiver. Another hospital uses behavioral interviewing techniques to understand whether candidates are team players or not, and how they will interact with patients. This is followed by on-boarding and competency assessments and training to ensure alignment with its patient-centered mission.

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Some hospitals have extensive compassion training upfront. One teaching hospital addresses the topic with residents the morning of the first day of orientation, including training on "difficult conversations." A teaching hospital where "patient primacy" guides the hiring process makes it clear to physicians that they have to buy into the philosophy in order to be successful.

At many hospitals, compassion begins with the first interaction – whether in the parking lot, at intake, on the phone, or at admission. Several sites have developed patient-focused questionnaires used at admission, entrusting staff with identifying critical issues or early interventions before the patient gets to a unit. Questions include: "What should we know about your life at home?" and "What can we do to make your experience here less stressful?" This helps determine what kind of preconceived fears patients and families bring with them, so the care team can address these fears.

Professional education and training, which enhance caregivers' abilities and self-confidence, now go well beyond traditional clinical skills training. In particular, training programs to improve patients' experiences of care are now widespread. These include simulations using model conversations and videotaping, with variations such as using actors to pose as patients.

All of the hospital and health system leaders interviewed provided examples of training programs but the emphases varied. Some were more robust in patient experience, others in patient- and family-centered care. Most had multiple layers of education for staff at different levels. One offers special training programs for nurses; another holds mini-retreats that show staff how every member of the organization can contribute to building stronger relationships with patients and families.

One hospital has monthly sessions for physicians, nurses and other frontline staff on the delivery of patient-centered care (active listening skills, simulations, etc.), supplemented by quarterly lectures for physicians with a focus on patient interactions. Another holds 150 workshops a year for frontline staff on empathy, while still another involved more than 6,000 employees in helping to define 10 behaviors of respect that are now part of mandatory team training on empathy and empathic experience.

A safety net hospital interviewee said that a significant barrier to compassion at her institution is that physicians and nurses do not always understand what it means to be poor. "Often, cancer is not the worst thing our patients are facing," she said.

In some cases, senior leaders said, different approaches may be necessary to bridge generational and professional divides.

• **Younger staff members need more training and support.** Younger nurses and medical residents must be taught compassion and how to deal with stressful situations through repeated trainings. Although simulations are effective, these younger staff members need an environment that encourages discussion and mentoring, which promotes the sensitivity and awareness that lead to fewer errors and better care.

• **Physicians present special challenges.** Communication and inter-personal skills training work well for younger physicians, but results are mixed for older physicians. For older physicians who are seen to lack compassion, hospitals tend to rely on direct conversations, financial incentives and professional peer pressure.

• **Hospital type, specialty and physician status matter.** Large teaching hospitals tend to have more consulting physicians who may not be as engaged and may not see patient experience and compassionate care as shared priorities. A safety net hospital leader said that a significant barrier to compassion at her institution is that staff do not always understand what it means to be poor. "Often, cancer is not the worst thing our patients are facing," she said. A senior leader at a specialty hospital said that one downside of specialization is that "sometimes they [the physicians] can be more focused on the disease than the individual."

Finally, many hospitals and health systems provide financial and other incentives to staff to improve patient experience and encourage more compassionate care, including:

• **Rewards:** Some organizations offer rewards and recognition to a few top performers; others have a deep system of frequent rewards. Some have physician incentive bonus pools tied to patient experience scores; some are individual rewards, and some are shared with units or departments. Many build patient experience performance into formal reviews, but only infrequently is it tied to professional advancement.

• **Perquisites:** Others offer perks, such as concierge services, wellness courses and training days to encourage clinicians to provide an exemplary patient experience.

• **Individual awards:** Every organization has its own brand of individual award, in addition to nationally recognized awards (e.g., the DAISY award for nursing or the Schwartz Center National Compassionate Caregiver of the Year Award for caregivers who demonstrate exemplary compassion).

• **Team awards:** At one hospital, staff in a department that scores highly in the area of patient experience picks another unit that helped it achieve that goal, and the award is shared. At another hospital, the award travels quarterly, with the department that won the previous quarter presenting it to another unit that has helped it improve during the current quarter.

4. SUCCESSFUL ORGANIZATIONS HAVE A CULTURE OF EXPERIMENTATION, COMPASSIONATE CARE CHAMPIONS, AND UNITS THAT MODEL COMPASSIONATE CARE.

Regardless of hospital or health system, off-the-shelf solutions are the exception not the rule. Although many organizations are influenced by the recommendations of consultants or the content of packaged programs, senior leaders said they typically adapt the recommended approaches to address their specific needs.

Developing tailor-made solutions requires a culture of experimentation and entrepreneurship. Senior management support is essential, since a willingness to try new things involves risk. Successful institutions encourage new ideas at all levels. For example, at one hospital, nurses put together an interdisciplinary response team from units across their specialty hospital to address patients' most immediate needs and concerns; at another, a physician group pays doctors a small fee to conduct "continuity visits" to encourage them to spend more time with patients at the bedside.

Often, there is a mid-level champion who is passionate about his or her role and becomes the recognized leader of quality improvement efforts in this area. As one committed champion said, "You can't give this to a marketing department." Having a compassionate care champion can ensure sustainability and consistency; the downside is that if the champion leaves the organization and there is no leadership from the top, momentum may be lost.

Most enduring change occurs at the unit level. Successful hospitals have departments or units that model compassionate care leadership, creativity, innovation and teamwork. One teaching hospital created a unit, headed by an ethicist, which is on call for consultations with individual caregivers or teams facing particularly difficult patient and family situations. Another created a unit team model that can best be characterized as the "CEO of every unit." The team includes a patient services manager (typically a nurse manager) and a medical director who are charged with managing the unit as if they were the CEO. The challenge is to empower every unit in the hospital to create an environment that promotes the precepts of "Don't hurt me, heal me, and be nice to me."

"You can't give this to a marketing department." – A senior leader

Factors Most Critical to Compassionate Care*

1. Capable and dedicated champions
2. Departments or care groups that model compassionate care
3. Visible support from the CEO and other senior leaders
4. Making patient experience scores transparent
5. Dedicated patient experience officer
6. Substantial budget devoted to patient experience and compassionate care

*Based on a survey of 67 Schwartz Center Rounds clinician leaders conducted as part of this project

5. COMPASSIONATE CARE REQUIRES CONTINUITY OF CARE AND TEAMWORK.

According to those interviewed, compassion doesn't start or stop with an individual caregiver at the bedside. It must include the entire care team and take into consideration care transitions. Within the hospital, senior leaders cited shift-to-shift reporting at the bedside as an innovative practice that promotes compassionate care. Patients and families can hear what happened over the past eight hours and ask questions. Patients feel more confident when they know who is taking care of them, and when they see that their new caregiver team is well informed.

Almost all of the hospitals provided examples of building better caregiver teams. One hospital has a three-year organizational initiative to promote team-based care as a way to implement several new programs: purposeful rounding, shift change at bedside, and inter-professional rounds to develop the daily plan of care. Nurses reported that moving to team-based care has made a difference in patient and employee engagement, trust, and the quality of physician care. However, the process is not always easy. One senior leader characterized the challenge as "shifting the [physician] culture from 'captain of the ship' to member of a team."

To ease the transition outside of the hospital, longitudinal care managers are making a difference at some hospitals, following patients as they move to rehabilitation and nursing facilities or return home. One hospital asks that all discharged patients have a designated care partner, typically a family member or friend, who can help ensure that transitions go smoothly. Another reaches out to long-term care facilities and asks them to participate in its culture change efforts, including efforts to reduce readmission rates. This also works in the opposite direction, with long-term care centers asking hospitals that refer to them to do the same.

One large hospital assigns an attending nurse – who the hospital calls its "secret ingredient" – to reach out to patients and help coordinate their care. It has developed a continuity of care survey to follow up with patients after they leave the hospital and is piloting a program to provide direct transportation to nursing homes to make transitions in care easier for patients and families.

Often cited as an important structural change was giving joint responsibility to a physician and nurse manager – to create more buy-in and improve coordination of care, patient and employee satisfaction, communication and health outcomes.

Nurses reported that moving to team-based care has made a difference in patient and employee engagement, trust, and the quality of physician care. However, the process is not always easy. One senior leader characterized the challenge as "shifting the [physician] culture from 'captain of the ship' to member of a team."

6. TRANSPARENCY IS A POWERFUL TOOL TO IMPROVE PERFORMANCE.

Public reporting of patient experience scores through the federal government's Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) makes improvement a competitive necessity. HCAHPS asks patients to rate their specific inpatient experiences and measures perceptions of the overall hospital experience. Many hospitals use their own or private patient satisfaction surveys to supplement HCAHPS, but HCAHPS results provide national metrics that allow comparisons to be made across hospitals and health systems.

Since HCAHPS is also a criterion for determining Medicare incentive payments under the federal government's Value-Based Purchasing Program, it is an obvious financial motivator for many hospitals. Hospitals are measured and rewarded (or penalized) based in part on their patient experience scores, and that drives the attention of patients and families, administrators, clinicians, staff and the media. Even if a hospital does not participate in Medicare, HCAHPS scores can affect physician and administrator incentive programs and unit or department rewards.

Hospitals and health system leaders say transparency is a powerful tool, and regular reporting of standardized scores produces results. One senior leader said, "If you publish it, people will pay attention to it." With the inception of HCAHPS, hospitals have become more competitive amongst themselves. The data are also incentives for internal change, even stimulating competition among units. A review of a patient experience dashboard is part of weekly or bi-weekly procedure at most sites. One hospital expects the worst performing units to look internally to the practices of the best performing units in order to improve. Another hospital openly displays survey scores for everyone – including patients and families – to see, and they rank order the units.

It should be mentioned that while HCAHPS scores are not an optimal measure of compassionate care, some of the questions asked, particularly those related to physician and nurse communication, correlate with the SCCH definition. Until better measures can be developed, the HCAHPS survey is the only tool available to assess some aspects of compassionate care. Better tools are needed.

"If you publish it, people will pay attention to it." – A senior leader

HCAHPS Survey Items

1. Communication with doctors
2. Communication with nurses
3. Responsiveness of hospital staff
4. Cleanliness of hospital environment
5. Quietness of the hospital environment
6. Pain management
7. Communication about medicines
8. Quality of discharge information
9. Overall rating of hospital
10. Recommendation of hospital

7. SIMPLE TACTICS CAN MAKE A DIFFERENCE.

Some hospitals interviewed apply continuous quality improvement techniques to improve patient experience, while others simply use a suggestion box. When scores were low for its emergency room, one hospital hired a patient advocate for busy shifts to help coordinate care. When nurses spend too much time "hunting and gathering" – looking for supplies or finding equipment – they are not spending enough time at the bedside, one senior leader said, who described efforts to better locate equipment and supplies. Even things like reassigning aides and transport personnel or changing food service protocols can strengthen patient-caregiver relationships and enhance compassionate care, another senior leader said.

Some sites are simply finding a better way. One question on the HCAHPS survey asks patients how often their rooms are quiet at night. One physician remarked that patients are often woken up at night to be given medications, to record vital signs, or to draw blood. In an effort to reduce these interruptions, he asked staff to call him at home if there was a medical need to wake a patient up at night for any of these reasons. When he didn't get a single call, the hospital changed the timing of medication administration and the recording of vital signs from shift change to 10 pm. This single action increased the hospital's patient experience score on this item from 16% to 47% without doing anything to change noise levels, while also signifying to patients that their need for sleep was foremost in caregivers' minds.

CONCLUSION

Healthcare CEOs today face a harsh operating environment in which there is little time to think solely about compassion and its impact on patient and caregiver experience and the bottom line. Among the list of top-ranking hospital CEO concerns, patient satisfaction currently ranks sixth and caregiver satisfaction does not appear on the list at all.

Patient experience leaders interviewed as part of this project believe that compassionate care is not only the right thing to do, but right for the bottom line. Driven in part by HCAHPS, identifying the return on investment (ROI) is seen by many as the Holy Grail.

In this context, healthcare CEOs and senior leaders are encouraged to view ROI through a different lens. Even a cash-strapped organization can foster compassionate care and a better patient and caregiver experience if it values compassion. Compassion is about improving relationships among caregivers, patients and families, not capital purchases. Intent, mission and values have no dollar cost. Attitudinal and behavioral changes, while requiring leadership and the investment of time, can result in better health outcomes, lower costs and greater patient and caregiver satisfaction – all of which benefit the bottom line.

Top Ranking CEO Concerns

1. Financial challenges
2. Healthcare reform implementation
3. Government mandates
4. Patient safety & quality
5. Care for the uninsured
6. Patient satisfaction
7. Physician-hospital relations
8. Population health management
9. Technology
10. Personnel shortages

Source: 2014 American College of Healthcare Executives (ACHE) survey of 388 hospital CEOs

APPENDIX

Hospitals and Health Systems Interviewed

Akron Children's Hospital, Akron, OH*

Boston Medical Center, Boston, MA*

Carolinas Healthcare System – Mercy, Charlotte, NC*

Cincinnati Children's Hospital Medical Center – Cincinnati, OH*

Cleveland Clinic, Cleveland, OH

Dartmouth-Hitchcock Medical Center, Lebanon, NH*

Griffin Hospital, Derby, CT*

Heart Hospital Baylor, Plano, TX

Hennepin County Medical Center, Minneapolis, MN*

Intermountain Healthcare, Salt Lake City, UT**

Kaiser Permanente, California**

Lahey Health System, Burlington, MA*

Longmont United Hospital, Longmont, CO

Magee-Women's Hospital of UPMC, Pittsburgh, PA

Massachusetts Eye and Ear Infirmary, Boston, MA*

Massachusetts General Hospital, Boston, MA*

Mayo Clinic, Rochester, MN

Montefiore Medical Center, New York, NY*

Mount Auburn Hospital, Cambridge, MA*

New York Presbyterian Hospital, New York, NY*

NYU Langone Medical Center, New York, NY*

Ohio State University Wexner Medical Center, Columbus, OH*

San Francisco General Hospital, San Francisco, CA*

Providence Health & Services, Pendleton, OR*

Saint Mary Medical Center, Long Beach, CA

Stamford Hospital, Stamford, CT*

Stanford Hospitals and Clinics, Palo Alto, CA*

Tenet Healthcare, Dallas, TX**

University of Alabama Health System, Birmingham, AL*

University of Maryland Medical Center, Baltimore, MD

University of Pittsburgh Medical Center, Pittsburgh, PA

University of Texas MD Anderson Cancer Center, Houston, TX

University of Washington Medical Center, Seattle, WA*

Virginia Mason Medical Center, Seattle, WA*

Yale-New Haven Hospital, New Haven, CT*

*Schwartz Center members

****Some of the hospitals within these systems are
Schwartz Center members**

Members of the Harvard CAP Team

Steve Diamond, Team Leader

Steve is a partner at the Globalpraxis Group, where he advises service companies on issues of strategy, marketing and sales management. He was previously a partner at the MAC Group. Steve has consulted widely throughout North America, Europe, Asia and Africa. A frequent speaker, he has taught executives at the Wharton School, the Kellogg School of Management, and Skolkovo (Moscow) as well as in-company programs. He graduated from the University of Pennsylvania and received an MBA and Doctorate from the Harvard Business School where he was a Mead Johnson Fellow in Marketing.

Jehan DeFonseka

Jehan is a consultant at The Brattle Group, which answers complex economic, regulatory and financial questions for corporations, law firms and governments around the world through rigorous analysis. His research focuses on nutrition and healthcare, and he also has expertise in structured transactions, financial markets and tax matters. He began his career at UBS. He graduated from MIT with degrees in electrical engineering/computer science and economics and received an MBA from the Harvard Business School.

Judith Fagin, PMP

Judith is a consulting project management professional specializing in healthcare and collaborative projects in other fields that involve the nonprofit, public and private sectors. Prior positions in healthcare include director of operations at New York University School of Medicine and director of project management for the nation's largest radiologist-owned physician practice based in Michigan. She received her MPA with a concentration in healthcare from the Harvard Kennedy School, and holds degrees from Tulane University (art history) and the University of Miami (architecture).

Sarah Mullen Rich

Sarah is an independent healthcare consultant who previously served as vice president of operations at St. Elizabeth's Medical Center in Boston, director of strategic operations at Tenet Healthcare, and associate administrator of St. Vincent Hospital in Worcester, MA. Before entering the healthcare field, she was an associate at Joseph Littlejohn & Levy and an analyst at J.P. Morgan. She graduated from the College of William and Mary with a degree in finance and received an MBA from the Harvard Business School.

Rob Savignol

Rob is a partner at the Boston-based private equity firm, M/C Partners, which provides growth capital to companies in the media, communications and technology services industries. Prior to joining M/C in 2004, Rob worked as director of corporate development for NTL, the United Kingdom's largest cable television provider. Rob began his career with Salomon Brothers in New York, focusing on mergers and acquisitions in the telecommunications industry. He graduated from Boston University with degrees in finance and economics and received an MBA from the Harvard Business School.

Melissa Weiksnar

Melissa is a writer, speaker and advocate in the field of substance use disorder prevention and treatment. Previously, she spent 10 years teaching high school students. Her early career spanned engineering, operations and financial roles at Conoco, the Medical Division of Hewlett-Packard, and Apollo Computer. In 1988, she co-founded the networking company, Synergetics, which was acquired by 3Com in 1994 and where she continued to work until 2000. She has a bachelor's degree in economics from MIT, a master's degree in systems engineering from the University of Houston, and an MBA from the Harvard Business School.