Microdosing

The Anatomy of Health System Naming

Expanded Macro Report

Paul Schrimpf

Microdosings are typically short reports on healthcare topics, grounded in expertise and best practices. This is an expanded version of it.

For all the amazing things a health system can do these days, too many of them still struggle with a couple of simple things: what goes on the sign and what goes on the bill. Think about it. In about three hours, a patient can get an entirely new hip and be walking within the week, if not the next day. Now consider what it takes to navigate a hospital campus or decode a medical bill. If the same science that went into the surgery went into the wayfinding, navigating a health system would be easier. The following is designed to put structure and alignment around generally accepted best practices as it relates to naming systems.

Health systems name two different things: places, where patients go, and the care-delivery organizations that determine what care is offered and who provides it. Places need a location naming stack that gets a patient to the right door. Care-delivery organizations need a services naming stack that lets patients, clinicians, schedulers, payers, and billers identify the care and the provider without translation. Problems begin when a name from one stack is used in the other.

Location stack *Where do I go?*	**Services stack** *What care, and who provides it?*
System	System
Campus / medical center	Physician group
Hospital / building / tower	Type of care / service line
Pavilion / wing	Institute (where warranted)
Floor / suite	Network
Elevators / stairs / connectors	Healthcare Professional

Two rules hold across both stacks, and settling them first resolves most of the debates that follow: signs are for places, and directories are for services and people. The following is an explanation of those two stacks, working down a campus (AKA Medical Center) from the system name to the front door, then across the org chart from the physician group to the network.

Introduction

What this covers and what it doesn't

Naming systems, brand architecture, and donor recognition are three different disciplines. This piece covers naming systems alone, as they relate to easy navigation of a health system and to patient experience. It assumes a strategy of a unified enterprise brand. Systems running a deliberate multi-brand portfolio, whether from acquisition integrations, durable legacy equity, joint ventures, academic affiliations, or multiple regulated entities, need a brand-architecture analysis before applying these naming rules. Unique campus and hospital names are covered below. If the same patient sees two different brands for orthopedics and for cancer, that is not best practice, and it is not the focus of this report. Nobody likes seeing a bill with one brand on top, and several different ones listed in the body. For anyone about to name a new hospital, medical center, or outpatient location, the naming stack below is the working part of this piece.

Brick and mortar versus people

The two stacks are interrelated but not interchangeable, and each one requires its own approach to naming and wayfinding. Take banking, for instance. One customer may hold a checking account and a home loan at the same bank. At the branch, that customer sees two different people about those two different financial products. That same branch sells countless other products: credit cards, certificates of deposit, small business loans, and more. Now consider the signage outside the bank. Does it say, Hometown Bank – Checking, Savings, Lending, and Investment Services? No. But it happens in healthcare all the time.

It is not uncommon to see a sign from a health system that says, Hometown Health Primary Care, Orthopedics, and Pediatrics on a single sign. Then two years later, someone wants to add Women's Health, and that spurs several weeks of debates on what goes on the sign. Few consumer-facing industries routinely put a changing menu of services on primary location signage, not because they never face the question, but because they settled it long ago. In healthcare, leadership teams can spend disproportionate time debating service labels on a sign when the underlying decision rule has never been settled.

The first step in setting a clear naming system is separating people, services, and location. Signs are for addresses. Most non-emergency visits require an appointment. A health system's signage isn't 7-Eleven signage, which exists to get people to pop in. There are only two exceptions, urgent care and freestanding emergency departments, and both are handled in the outpatient section below. One rule outranks everything that follows: emergency care must be the simplest, fastest, and least ambiguous destination on the campus. The rest of your signage doesn't need a lot because the patient has an appointment and has been given a specific location to go to. You don't need to re-market yourself to someone who already has an appointment with you.

Brand goes on top, and stops there

It is worth being direct about where branding belongs, because that is the argument underneath almost every debate a naming committee has. The system brand goes on top. It matters, it does real work, and it is the one name that has to appear everywhere a patient encounters the system. That is its role, and it is an important one. The trouble starts when the branding keeps going down: into the campus, the building, the pavilion, the floor, the service line, and the institute, until every level of the naming system is carrying a message instead of an instruction.

Naming a location and defining what something is are acts of definition, not acts of brand expression. A patient reading a sign, a scheduler reading a chart, and a driver reading a map all need to know what the place is and what happens there. Brand language pushed into those levels does not create distinction. It adds an interpretation step at the moment a person has the least patience for one.

Branding deep into the naming system is also bad for the brand. Equity accrues to the name on top when everything underneath it is easy to use. Every invented descriptor below the system name divides attention, dilutes the one name worth reinforcing, and puts the brand's fingerprints on a frustrating experience. Bad naming design and bad brand strategy are usually the same decision seen from two sides. Said differently, don’t get cute with the way you describe things deep in your portfolio. It only hurts you, the patients, and everyone in between.

Common words are an access feature

Health systems often reach for elevated labels: health campus, care pavilion, healing center, advanced-care institute. They sound broader, more modern, and more distinctive than the words patients use every day. The instinct is understandable. It becomes a problem when the label replaces the functional term a patient needs in order to navigate.

A patient should not have to work out whether a health campus contains a hospital, an emergency department, an outpatient center, a physician office, or all four. Campus is a useful geographic descriptor for a collection of facilities, but it is not a substitute for the name of a specific destination. If the patient is going to the hospital, call it a hospital. If the patient is going to urgent care, call it urgent care. If the patient is going to an imaging center, call it an imaging center.

In practice that means wrapping the enterprise brand, and any approved legacy, donor, or differentiating descriptor, around the functional term rather than using it in place of one. Hometown Health North Campus, Hospital, Main Entrance works. Hometown Health North

Health Campus leaves the patient with another question. The workable limit is simple: use health campus only for the campus, and never as the sole patient-facing term for the hospital or another specific destination inside it. A campus is a place. A hospital is a destination.

Plain language is an access feature. Communication in healthcare has to be understandable the first time it is seen or heard, and patients are often anxious, in pain, unfamiliar with the system, reading in a second language, or helping someone else reach care. Familiar terms reduce the work required to find the right door.

Accessibility is broader than ADA compliance

A vague or elevated name is not an ADA violation. ADA and ABA sign standards address physical and visual accessibility, including tactile characters and Braille on certain permanent room-identification signs. A name can be legally permissible, visually compliant, and still cognitively inaccessible.

Accessibility here means more than whether a sign meets its technical requirements. A patient-facing name also has to work under stress, unfamiliarity, limited health literacy, language difference, disability, and digital mediation. An elevated label or coined names creates an access risk on every one of those fronts: the person has to interpret an institutional label instead of recognizing a place, the term gets less useful when translated or relayed by a family member or a driver, people in pain or fear have less capacity to infer meaning, and search engines, maps, voice assistants, portals, and appointment reminders all work better when the care setting is named outright. A wayfinding name succeeds when people recognize and act on it quickly, not when it looks distinctive on a sign.

Gratitude belongs on plaques, not in wayfinding

One rule applies at every level of the stack below, so it is worth settling first. Donor names and wayfinding names are two different systems doing two different jobs. Without donor gifts and capital campaigns, much of what a health system builds would not be possible, and that generosity deserves proper, bold, permanent recognition. Dr. Merriweather Smith may have funded the construction, and his name should get a big old plaque on the building, maybe even carved in granite above the front entrance.

What his name should not get is the building's official wayfinding name. It is fair to assume no donor set out to confuse patients or make a campus hard to navigate. The last thing a lost, ailing patient wants to hear is, "Oh. You're in the wrong building. You want to go to Merriweather." That will be heard as a different branded health system and be perceived as incredibly confusing.

Location Naming Stack

Architecting the locations of care delivery

Each level below answers one question for a patient. The system answers who is accountable. The campus answers what part of town or neighborhood. The building answers which address to drive to. The wing or pavilion answers which part of the building. The floor and suite answer where inside. The elevators and stairs answer how to get there. Those six levels walk down a medical center campus from the top. The last entry steps off campus, to the outpatient and ambulatory sites where a growing share of care is delivered. Start at the level being named. Every entry follows the same four beats: what the level is, whether it gets a name at all, whether that name belongs on a sign, and the failure mode to avoid. Not every level needs a name, and not every building needs one either.

One rule sits above all of the levels that follow: use the most familiar, functionally precise term that a first-time patient or caregiver understands without translation. A location name should tell a person what the place is, what kind of care happens there, and, where it matters, whether it is the destination for emergency, inpatient, outpatient, urgent, imaging, surgical, or specialty care.

System

The name on top always matters the most. It says who is behind it all. The one in charge. The one accountable. It spans services and it spans locations. It is the name that ties it all together and is seen digitally, where most patients experience the system before, after, and in between visits. It's the glue. It's the name that provides cohesion and continuity, and ideally a connected patient experience. Ideally it reinforces that wherever that name appears, the patient is still in network. Not lost. Not about to be surprised. Not about to fill out another clipboard of medical history. The failure mode at this level is rare but expensive: any location that does not visibly carry the system name reads to a patient as somewhere else, and possibly out of network.

Campus/Medical Center

No level in this stack draws more debate than the campus, and almost none of it changes how a patient finds the right door. It is worth a few paragraphs to explain why. Start with what a campus actually is: a large, multipurpose plot of land with multiple buildings and entrances. It often has dedicated operations tied to its facilities, where security and maintenance teams might work across buildings, but their annual responsibilities are tied just to that campus. It usually has a geolocator name such as North Springfield Medical Center, Southern Delaware Campus, or perhaps a legacy moniker such as Lutheran General.

They have names, but are not addresses. They are more like neighborhoods of a health system. Think of Manhattan, Midtown Manhattan, or Harlem. They are bona fide geographic locations but not addresses. No mailing address has Midtown Manhattan on it. Nobody is in charge of Harlem. It will show up on Google Maps, and people will use it for navigation, but it's not hard-wired into a formal system. It is common and informal. It exists, and it has a role, but it is not wired into the formal address system. And if the medical center sits in a defined suburb, give it the name of that suburb.

It may or may not need to go on any signage. A monument sign over the campus that says Hometown Health Oak Ridge or Hometown Health West Knoxville is fine. But it would be highly unusual to have two medical campuses near each other, and most people know what area of town they are in. So the sign up top can simply say, Hometown Health.

The key point here for patient navigation is that medical center names play a role informally. They do not have specific addresses. For example, NewYork-Presbyterian Irving Medical Center has fifteen different entrances for patients. The campus name will get a patient into the vicinity, but it is not a specific location.

The campus or medical center name is also immaterial for reimbursement, though the door a patient walks through is not. For example, a procedure to repair a hernia in an outpatient location of a medical center will be reimbursed differently than if it was for an admitted patient. An emergency department also carries distinct legal obligations under EMTALA, including a medical screening exam and stabilizing treatment regardless of ability to pay. An urgent care center carries no such duty. Coverage and patient liability are separate questions from access, and they turn on the setting the visit is registered into.

So while a medical center is big, highly noticeable, and frequently mentioned, its name isn't the most important. It's important, but not the most.

Hospital/Building/Tower

Hospitals and medical centers are different things, and the difference matters to a patient. A hospital is a specific destination. A medical center or campus is usually a broader geographic collection of buildings and services, and a hospital sits within it. The two terms can coexist, but they cannot be used interchangeably when a patient needs to identify the building that provides inpatient or emergency care. Use the familiar functional term first: if a facility is a hospital, then the patient-facing name, the directions, the map listing, the appointment instructions, and the wayfinding should all make "hospital" visible. A system can keep a legacy or formal institutional name, but it should not require patients to infer that a health campus, a medical center, or a care institute is the hospital they are looking for. Location descriptors are for navigation and ease of understanding. The clearest evidence is

that the standard has already been set for every health system in the country, and not by a health system. U.S. traffic-control standards settled it. The blue "H" guide sign, defined in the federal Manual on Uniform Traffic Control Devices and posted on public roads nationwide, directs drivers to one thing, and it stands for one word: Hospital. Not medical center. Not health campus. Not infirmary.

That has a practical consequence. The public roads leading to a facility are already labeled Hospital, so the patient following those blue H signs arrives expecting to find a hospital. If the sign at the driveway says North Health Campus and the monument sign says Merriweather Pavilion, the system has broken the chain of instructions the patient was given by the road. The building the H points to should be called a hospital, in the wayfinding, in the map listing, and in the appointment instructions. A health system does not get to opt out of a naming convention its patients are already following at 35 miles per hour.

Hospitals have addresses, which is what makes this the most important level for patient navigation. They should have “main entrances” where an information desk is the first thing people see, and clearly marked emergency room signage. In industry and regulatory terms (CMS Medicare Conditions of Participation, state licensure), a hospital is a licensed institution primarily engaged in providing inpatient care: it admits patients to stay overnight, maintains 24-hour physician and nursing coverage, and holds a licensed bed count. That inpatient capacity is the dividing line compared to other care settings.

In medical centers where the hospital function lives in multiple buildings, this is where building and tower descriptors come into play. When managing a large eclectic set of care sites, officially name the building or tower North Tower, Blue Building, or Tower Three.

Pavilion/Wing

In the world of health system naming, pavilions and wings are little sisters to medical center naming. They play a role, but are more informal. They usually originate in a capital campaign, and the trouble starts when a recognition name is asked to do wayfinding work. They are a partial structure, an addition, or a space within a structure. This is the level where the donor rule above gets tested most often. A nice statue of William & Terease Montague in the new pavilion is welcome. The wayfinding still lists it as the South Pavilion.

Floor/Suite

Floors and suites, interestingly, cause the fewest problems of any level in the stack. It’s very common to say third floor, room 319. That same discipline should extend beyond floors and suites to the rest of the wayfinding system. It usually stops there because a distinctive

descriptor feels like it should shift perception. Calling a new hospital a health center does not change how patients judge the care inside it.

Health systems would never name a floor the Patel floor, or put thirty different donor names on all of the med-surg rooms. Floors and suites might be occupied by distinct departments. And casually, one might say, “the rehab floor”, but it carries a number, linked to a button on the elevator.

Elevators and Stairs

Larger medical centers often have multiple elevator banks and stairwells. They need descriptors too. It’s a common place where patients, families, and visiting clinicians quickly get lost. Same logic applies. Be clear. Be boring. Be safe. Reduce anxiety during an anxiety-riddled event.

Outpatient/Office/Clinic

Everything above sits on a medical center campus. This is where the stack steps off it. Outpatient buildings carry their own addresses, the way hospitals do, and with more care being delivered outside the hospital, naming them will grow in importance. Most care sites operate by appointment, and many require a referral. Meaning once again, the signage has a very simple job: clearly show the address and the health system brand. Whether the patient is going for primary care, rheumatology, or to have their labs done, they have a scheduled appointment. Primary care does not go on the sign. Primary care is one of the services within, and maybe countless others.

Outpatient facilities tend to be smaller and less confusing to begin with. Therefore, less is more with facility naming. For official purposes, call it an outpatient center, or a surgical center, or an imaging center. Most people are coming there to see a specific clinician, or to have a procedure done by a specific doctor. Once inside, have a proper directory or information desk so they can find that clinician.

The same rule applies off campus. Outpatient center, clinic, medical office building, imaging center, and surgery center are not less sophisticated because they are descriptive. They are more useful, because they tell a patient what kind of destination they have reached.

Then there are the two outpatient services that are on-demand and welcome walk-ins. They are urgent care and freestanding emergency departments (FSEDs). This is the one place where signage does double as marketing. It plays the role of, "If you need care now, come here." It also helps justify more measured signage everywhere else. A restrained sign that

says Hometown Health Outpatient Center implies it is not a walk-in facility, compared to a big bold sign that says Hometown Health Urgent Care 24/7, which implies come anytime.

Urgent care, freestanding emergency departments, and hospital emergency departments deserve particular restraint. These are the walk-in destinations where the sign also helps a patient decide whether this is the right level of care. Use the terms patients already recognize, Urgent Care, Emergency Department, or Emergency Room, and make the care setting unmistakable before the patient walks in. Distinctive brand language can support the name. It cannot obscure the clinical function.

The read-it-back test

Before committing to a set of names, read them back as instructions. Picture a care coordinator giving a patient directions for an appointment tomorrow. This is easy to follow: "Your procedure will be at our Hometown Health Knoxville West location. Go to the main entrance of building two, and head to the north wing." Compare that to: "Your procedure will be at our Hometown Health Presbyterian Medical Center location. Go to the main entrance of our Merriweather building, and head to the Montague Wing."

Using simple directions, numbers, and clear descriptors is unglamorous, but it is critical in reducing frustration in an already stressful visit, and it keeps patients safe. That is what health systems are in the business of. Branding efforts that obscure location or care-setting clarity create avoidable friction, and friction during a stressful visit is a safety issue. If the names cannot be read aloud over the phone and followed by a stranger in a parking lot, they are not finished.

The common-term test

The read-it-back test asks whether spoken directions can be followed. A second test asks whether the words themselves reveal the type of destination. If a first-time patient, a caregiver, a driver, or a referring office cannot identify the care setting from the noun in the name, the name is incomplete.

Descriptive is not generic. A common objection is that calling facilities hospitals, outpatient centers, imaging centers, and urgent care sites makes every location sound the same. It does not. The system brand, the location, clinical quality, clinician reputation, patient experience, outcomes, and digital experience are what differentiate a health system. The functional noun only ensures the patient knows what the destination is. A system can differentiate around the word hospital. It should not differentiate away from it when a patient needs to find inpatient or emergency care.

The last step: claim the name digitally

Naming a location is not finished when the sign goes up. Patients have searched for businesses online for thirty years, yet a naming process can run for months on the wording of a sign and never address how that name appears in a search result. Every location needs to be claimed and maintained in Google Business Profile and Apple Business Connect, with accurate names, addresses, phone numbers, hours, categories, and photos, and with consistent information across the system website and the major online directories. Update listings regularly, respond to reviews, and verify that map pins and provider details are correct so search engines trust and prominently surface those locations. That is just physical navigation, digitally.

Then there is syncing locations with payer partners, third parties like ZocDoc, and even making sure the patient portal is intuitive. Yet far too many health systems brand their patient portals as something else, and even when they don't, they cobrand it. Epic's MyChart is becoming more familiar to most patients, but it is still not intuitive to many. For good reason: it is Epic's branded patient portal, but it is normally exclusive to the health system. Clarity and cohesion in the physical naming stack is what makes this step easy. If the ladder is clean, the digital work is data entry. If it is not, the confusion follows the patient home.

Service Naming Stack

Architecting the types of care delivery

The first stack is an address book, and is tied to places. This one is an org chart, and tied to people. Everything above answers where a patient goes, and it is what ends up on the sign. Everything below answers who delivered the care and what that care is called, and it is what ends up on the bill. The components of this section need to go into a directory, both online and in the lobby, and participating provider lists with insurers. They don't necessarily need to be plastered on signs. Signs are for the name of the health system, addresses, and wayfinding. They don't need to describe your org chart to visitors. What does matter is that one name holds everywhere it appears, because when the sign, the claim, the credentialing file, and the payer directory disagree, the denial is not a coding problem. It is a naming problem.

The system name sits on top of both stacks and does not need repeating here. Below it, these levels are not nested the way buildings are. Each one describes a different kind of thing: what a patient came for, how the work is budgeted, who employs the clinician, and how the care is operated. Confusion at this level almost never comes from a bad name. It comes from a name describing the wrong kind of thing.

Physician groups

The first thing that tends to go sideways with physician group naming – particularly for wholly owned physician groups – is giving them a different brand name than the health system. Doing so unintentionally communicates that the physician group is separate from, rather than fully integrated with, the health system, even when it is owned, governed, and operated by the same organization. That weakens the connection patients, referring providers, employers, and payers naturally make between the physicians and the broader network. It can also create unnecessary friction in provider directories, insurance verification, referrals, and billing when multiple names appear to represent different organizations, even though they are part of the same enterprise. Over time, the health system also misses opportunities to strengthen its master brand because the recognition and reputation earned by the physician group do not automatically accrue to the parent organization.

That last part is worth repeating. Separate physician group naming is often born from the idea that this group is special and better. That is often true. So why would a health system own and operate a high-performing physician group, and have all of that brand equity go to a different brand? Why would a health system spend that capital and recruit that clinical talent, only to have the resulting reputation attach to a brand other than the one that paid for it?

This also helps with billing and referrals to partner networks or contracted physicians. Many procedures require physicians from groups the system does not own. There, it makes sense for them to be listed on bills with different brands, as they are not employed by the health system.

Types of care and service lines

These are the organizing principles and words patients already use: primary care, OBGYN, cardiology, orthopedics, imaging, labs. This level does not need a name invented for it. It already has one, and it is whatever a patient would type into a search bar or say out loud to a scheduler. The discipline here is restraint. A system that renames its cardiology service something proprietary has not created distinction; it has created a translation problem for every referral, every directory, and every search result. Use the plain term. Save the creativity for the parts of the business where it earns something.

This is also the level most likely to end up on a sign, which is where the first stack already said no. Services belong in the directory inside the building, not on the monument sign outside it.

There will also be great debates about the specific descriptors. Is it Orthopedics or Bone & Joint? Is it Cardiovascular or Heart & Vascular? It's usually best to err on more generic terms. Remember who the name is for: a patient searching in plain language, not a specialist reading a directory. Clinical preference and professional terminology should not override the words patients actually use to look for care. Plenty of large, well-regarded groups already market themselves as Bone & Joint or as a Cancer Center for exactly that reason, and service line leaders can live with the same choice.

Institutes

Most people use Institute, Physician Group, and Service Line naming interchangeably. They shouldn't. They often add the institute descriptor to add more prestige to the name, but don't always define it. There are no general best practices for usage. If it is just a group of employed physicians that don't own ORs or capital-intensive facilities, it's just a physician group. If it does manage substantially more than just people and clinicians, and include facilities, special equipment, etc. but doesn't do research, nor receive grants for research, doesn't teach, nor host clinical trials, it's more likely just a service line. If leaders want the institute descriptor, the question is not whether they can call themselves one. It is how they can qualify for it. If a name is meant to be special, the expertise and experience needs to be special.

Networks

Networks are their own beast, and the reason is audience. Every other level in both stacks is graded on whether a patient understands it. This one also includes insurers, as many patients navigate their care via insurer directories. Patients are also more loyal to providers than payers, and more likely to declare themselves a Hometown Health household, and want those physicians in network.

A network name should be precise enough for a contract and boring enough that a patient who stumbles across it draws no conclusion from it. A patient just wants to know if a future doctor is in network. If their primary care physician is covered and part of Hometown Health, then when they see a dermatologist in the Hometown Health network, they assume they'll be in network too, and not get a surprise bill. Remember, it's hard to get doctor appointments and physician offices often don't have any better tools than patients. It's common for a patient to search networks to find a doctor in network, and available this week. If your network naming is confusing, you might be leaking patients.

Healthcare professionals

The last level is the most personal. Patients attach to a person, not a service line or a network: the physician, nurse practitioner, or physician associate who knows their history. Physicians have carried individual brands for as long as there have been shingles on doors, and advanced practice providers now carry the same recognition and loyalty. When a patient says they are going to see Dr. Whoever, that name is doing more navigational work than any sign on the building.

So treat a clinician's name like any other wayfinding asset. One spelling, one credential string, one listing per person, consistent across the online directory, the lobby, scheduling, and payer directories, and true at every site where they practice. Pair the name with the plain-language service and the location, in that order, so a patient can always answer one question: where do I find the professional who knows me best?

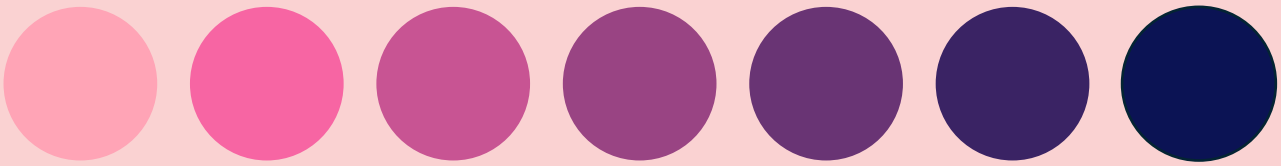
The org chart test

The first stack had the read-it-back test. This one has a shorter question: does the name describe what the patient came for, or how the system is organized to deliver it?

What the patient came for goes in the directory, the search result, and the scheduler's sentence. How the system is organized to deliver it stays on the org chart, in the budget, and in the operating review. Both are legitimate. They are simply not the same vocabulary, and the trouble starts the moment one gets used where the other belongs.

Summary

Reducing navigation barriers improves outcomes and revenue cycle management



Naming is not a creative exercise. It is an operating discipline. Patients have to find the right place, staff have to register the right encounter, payers have to recognize the right facility and provider, and every digital surface has to show the same thing. That is the work the two stacks do: the location stack tells people where to go, and the services stack tells them what the care is and who delivered it. Most naming debates are really arguments about which stack a name belongs to, and they end the moment that question is answered.

The rules that hold across both stacks are short. Keep one system brand visible across every location and every service. Put addresses and wayfinding on signs, and put services and physicians in directories. Give donors a plaque, and give patients a building number. Use the plain words patients already say out loud, and make the emergency department the easiest thing on campus to find.

Naming is also not finished when the sign goes up. A name has to hold up in a search result, a map pin, an insurer directory, an appointment reminder, and a claim, and that work is straightforward data entry only when the stack is clean.

There is also money in it. Naming discipline shows up in the revenue cycle as speed, consistency, and accuracy of reimbursement. A claim carrying the same facility and provider names the payer already has on file goes out clean instead of into a work queue. The sign, the credentialing file, the payer directory, and the claim all have to say the same thing. And the setting a patient is registered into determines how the encounter is paid, so a stack that blurs a hospital outpatient department into a physician office invites denials and appeals. Days in accounts receivable, denial rates, and rework hours are the financial ledger of a naming decision nobody thought was financial.

None of this is a branding exercise, and that is the point. Clear, boring, descriptive names cost a health system nothing and save patients the anxiety of being lost during one of the harder days of their lives. A name can be visually compliant and legally permissible and still fail the patient. If a person cannot tell from the words whether a place is a hospital, an emergency department, an urgent care site, a clinic, an imaging center, or an outpatient center, the name has handed the patient work the system should have done itself. If a name can be read aloud over the phone and followed by a stranger in a parking lot, it is finished. If it cannot, it is not, no matter how good it looks on the monument sign.