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Healthcare Executive Podcast

On a recent episode of the Healthcare Executive Podcast, ACHE faculty Jake Poore, president, Integrated Loyalty Systems Inc., talked about creating a blueprint for a world-class experience for patients and employees. He shared his expertise on elevating the patient experience in the age of social media, building a workforce committed to the brand promise, and the close link between patient and employee satisfaction. Visit HealthcareExecutive.org/Podcast to listen and browse through more episodes. The podcasts are also available through Apple’s iTunes.

Access the Magazine Online

The July/August 2019 issue of Healthcare Executive magazine is now online. We hope you enjoy the magazine’s online format and the fresher, more contemporary look and feel. In addition to the articles in the current issue, you can access previous issues and web-exclusive content. Visit HealthcareExecutive.org.

Execute on Population Health Management

Healthcare leaders steering toward population health management need to know the drivers of success. For example, understanding the importance of patient-centered medical homes as a holistic approach to primary care that improves care coordination is one driver of success. Discover more in the blog post, “On the Digital Road to Population Health,” by visiting blog.ache.org.
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CHANGE MADE POSSIBLE
Population health, value-based care and social determinants of health initiatives continue to develop in the field, with some of the major players demonstrating solid results to showcase. Leading organizations are paving the way for others to replicate their findings.

In our cover story “Population Health Turned Inward: Employee Health Successes” (Page 8), we discuss the healthcare field’s journey to population health and value-based care and the progress being made. Healthcare leaders and providers focusing on these initiatives and paving the way for others continue to work on what is needed to make one of the industry’s biggest transformations. And as with most journeys, there have been lessons learned, successes to celebrate and paths forward uncovered.

In the feature article “Caring for the Vulnerable: Confronting Social Determinants of Health Improves Outcomes” (Page 16), we examine health systems—large, small and in between—across the country that are proactively addressing societal issues that affect the health of their communities and patient populations. Five examples of hospitals and health systems are highlighted that have made investments in community health and are making a measurable impact on the wellness and stability of their patients.

In addition, you’ll find the Ethics Self-Assessment (Page 60), used to evaluate leadership and ethics-related actions, and to address potential red flags identified in the process. Each year, ACHE’s Ethics Committee reviews and considers revisions to the Ethics Self-Assessment. Typically, these revisions consist of minor changes, but in 2018, the committee added eight new statements to better reflect some of the larger issues at stake in healthcare today.

I hope you enjoy this issue of Healthcare Executive. Please share your feedback with me at echess@ache.org. ▲
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One of ACHE’s greatest assets is our community. There is tremendous strength to be found within the robust network of our membership; the collective knowledge and experience is impressive and should be shared. A strong and unified community is crucial as we all work to navigate the dynamic healthcare landscape; we can learn from one another, support each other and together ensure that our field has strong leaders to take us into the future.

Nationally and locally, the opportunities to give back to each other and our profession are vast. For decades, ACHE and its members have benefited from the participation of senior leaders who volunteer their time to serve. As one example, the efforts of experienced leaders have resulted in more than 1,500 mentoring partnerships. Of course, it’s impossible to quantify each leader’s numerous contributions. But suffice it to say, you make ACHE successful.

Equally important is the opportunity for senior leaders to support their local chapters. Through a broad network of 78 chapters, the strength and vibrancy of ACHE is alive and well. Right in your own backyard, members at all career stages are connecting with one another while also learning valuable leadership lessons and skills. Through our chapters, students discover the importance of belonging to a profession, while others participate to hone their knowledge and skills.

Through chapters, those less familiar with ACHE also have the chance to discover who we are. By funding innovation projects, chapters can test-drive new approaches that hold the promise of expanding our community to clinicians, to those working across the continuum of care, to early careerists and to many others. When we increase the diversity of our profession, different perspectives are shared that will help us more successfully navigate change, making healthcare safer, more affordable and more accessible. We know the work of advancing health will require new paradigms for leaders.

For these efforts to gain momentum and be effective and sustainable, they need senior leaders’ participation. Through your lens, the opportunities to educate, engage and inspire current and future leaders can be magnified. By sharing your experiences you have the opportunity to shape and strengthen our profession. There are various ways and time commitment levels that will allow you support your chapter and the leaders who benefit from its events.

Educate, engage and inspire others.

Showcase successful leadership strategies. Senior executives’ experience can serve as a treasure trove of information for new leaders. By participating in a chapter panel discussion—most are only 90 minutes—you can share hard-earned wisdom.

Contribute to professional development and educational opportunities. Provide a venue for a chapter activity by showcasing your facility or hosting a CEO/senior leader roundtable.

Cultivate the next generation of leaders. The opportunity to engage with senior colleagues as mentors will provide new leaders a chance to learn and develop the crucial leadership skills needed to navigate a successful healthcare career. You can volunteer to participate in career services activities or resume reviews.

Finally, remember that ACHE’s greatest strength is its members. Nationally and locally, our community is strong because of you. As a senior leader, you have much to offer to educate, engage and inspire others. By sharing what you know with others, you can help cultivate the next generation of leaders with the heart and soul that defines our profession. ▲

Deborah J. Bowen, FACHE, CAE, is president/CEO of the American College of Healthcare Executives (dbowen@ache.org).
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POPULATION HEALTH TURNED INWARD

Employee Health Successes

By Jessica D. Squazzo
In 2011, the healthcare field’s movement to population health and value-based delivery models was still very much in its infancy, as described in a November/December *Healthcare Executive* article that year. In a winter 2016 interview for *Leadership* magazine, David Nash, MD, dean, Jefferson College of Population Health, Philadelphia, gave the industry a “C” grade for its efforts in managing the health of its own employee populations, which many experts consider to be a good starting point for effective population health management.

Where does the field stand in 2019?

Though there have been some significant developments in the past five to seven years, it seems the healthcare field’s journey to population health and value-based care is still a work in progress. The healthcare leaders and providers focusing on these initiatives and paving the way for others continue to work on what is needed to make one of the industry’s biggest transformations. And as with most journeys, there have been lessons learned, successes to celebrate and paths forward revealed.

Stephanie S. McCutcheon, FACHE, CEO, Health Employer Exchange, Baltimore, describes this process as a long journey—not a swift
solution—and that progress is being made, with many healthcare executives still recognizing the importance of moving to value-based care.

“I think our field has really stood up,” she says. “Leaders in the field didn’t just say, ‘Oh, I’m not so worried about this. It will all work its way out.’ I think many said, ‘We must take on the leadership role and lead the evolution of it.’”

Nash, who also is The Raymond C. and Doris N. Grandon Professor of Health Policy at Jefferson College of Population Health, says the industry too is making progress on this journey. He finds similarities between today’s population health and value-based care transition and how the landscape changed after the publication of the Institute of Medicine’s *To Err Is Human: Building a Safer Health System*.

“I think more than ever, we’re starting to pay attention to issues that we never did before, especially the social determinants of health,” Nash says. “It is now socially acceptable to have these conversations. It reminds me when in 1999 *To Err Is Human* was first published, and all of a sudden talking about medical error was more acceptable.”

Emerging Success Factors: Value Readiness in 2019

Since 2011, several factors have come to light about what will be required for the healthcare field to take on population health management and value-based care successfully. First and foremost, McCutcheon says, is recognizing that taking initial steps on these initiatives is more important than perfecting them. In other words, don’t let fear immobilize an organizational initiative from getting started.

While experts agree most organizations in the field should be looking at value-based care and population health and at least considering how they can make moves into this arena, McCutcheon advises that all organizations adopt these types of changes at an appropriate pace. That is one of the most important lessons that has emerged since several health systems came together in 2012 to form the Health Employer Exchange.

The participating health systems—all self-insured—have developed and adapted a Value-Based Care Model and an Innovation/Transformation Approach & Methodology that they have replicated and scaled during the past six years across the participating health systems in which they used their employees as the “population” to be cared for and managed. Since HEE was founded, the group has developed 12 principles to reduce health plan and workers’ compensation costs and increase employee/enrollee satisfaction. Every six months, the health systems in HEE came together to share the principles they had adopted and enhanced—as not all work for all
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organizations—so others could learn from them and potentially deploy them across their organizations.

Replication of different care models (or “principles,” as HEE calls them) has emerged as a success factor in the move to value and population health. “I really respect these organizations for standing up and saying, ‘Can I do this faster and more effectively if I use the principles as adapted by another organization?’ Sharing across organizations is what really has potential when you’re going through an industry evolution the magnitude of this,” McCutcheon says.

Another important success factor in the move to value has been mindful selection of a population on which to focus. Experts agree that focusing on a population with which the organization already has some risk arrangement is a wise move. The health systems in the Health Employer Exchange chose their self-insured population—their employees—to implement their programs. This choice, McCutcheon says, works because the employer, the health system in this case, already assumes full risk for the population. Patients who are on Medicare Advantage plans—arrangements that for healthcare providers generally include a significant amount of risk but also substantial cost-savings opportunities—are another group organizations can consider when starting value-based care initiatives, according to McCutcheon.

“Many of the health systems and small hospitals, particularly rural hospitals, are really operating on thin margins, and that makes it a difficult time to walk away from potential revenue or income. We’re trying to forge ahead with bold moves that we hope make that journey easier for others.”

—Mikelle Moore
Intermountain Healthcare

Realigning Incentives While Reimagining Care
Salt Lake City-based Intermountain Healthcare has set out to transform care delivery at some of its primary care clinics. Called the Reimagined Primary Care Clinics, the model offers the organization’s primary care, family medicine and internal medicine physicians a different way to practice, according to Mikelle Moore, senior vice president/chief community health officer, Intermountain Healthcare, and an ACHE Member.

Several clinics within the integrated not-for-profit system—which has 22 hospitals, more than 185 clinics and a medical group with more than 1,500 multispecialty doctors and caregivers—are now participating in the model, in which physicians can choose between what Moore calls a “quasi-fee-for-service model”—physicians are compensated based on the traditional fee-for-service method but also based on their performance metrics related to quality, patient satisfaction and clinical practice improvement—and a panel-based employment model in which physicians are compensated based on their performance within a team-based care approach.
The fact that physicians can choose between the two models has helped quell physician uncertainty. “When we started talking about the new model and the option for a different structure and compensation, at first there was fear that physicians didn’t want to be forced to change into the new model,” Moore says. “We very quickly said, ‘Well we don’t need to force it. Let’s just operate those models side-by-side and allow physicians to self-select.’ We can even produce information about what compensation would have looked like under a different model to help inform decision making and create transparency.”

Feedback from participating physicians has been tremendously positive, says Moore. Intermountain currently has six physicians and three advance practice clinicians in the model and plans to have 20 more providers by June 1 (at press time) and 40 total providers by the end of the year. “We have more demand than we have bandwidth to do the conversion, and I think that speaks for itself,” she says. “The physicians are saying they really enjoy practicing this way.”

New Players on the Care Team
Milwaukee-based Froedtert & the Medical College of Wisconsin, a regional health network comprising five

A CEO To-Do List for Managing Population Health
Effectively managing population health and value-based care initiatives will require strategic and innovative leadership. David Nash, MD, dean, Jefferson College of Population Health, Philadelphia, provides a to-do list for CEOs—six strategies for better managing population health.

1. Begin population health management with an employee population. “We know that employee health and wellness is so central to productivity,” says Nash.

2. Keep the well “well.” “Keeping the healthy people healthy is a powerful social motivator,” Nash says.

3. Train leaders for value-based care. Leaders will need guidance for this transformation.


5. Partner with managed care plans. Every major organization is looking for provider partners, according to Nash.

6. Fund physician leadership training. “We can never get enough of this,” Nash says. “That should always be on the list.”
hospitals, an academic medical center, more than 1,700 physicians and nearly 40 health centers and clinics, is one organization embracing the journey to value-based care and population health through the strategic use of care coordinators. These team members are an extension of the doctors and nurses leading the care teams and have been instrumental in managing care transitions.

“If a patient visits the ED or is discharged from the hospital, they’re in a transitions of care category, and we help manage those patients so that we can hopefully reduce readmissions, reduce ED visits, help them get their medicines right and improve their health,” says Jonathon Truwit, MD, enterprise CMO of the health network.

Using care coordinators is done in conjunction with other population-health focused initiatives such as isolating patients with chronic conditions to better manage their care, according to Truwit. An array of digital solutions also feature prominently in these efforts at Froedtert & the Medical College of Wisconsin.

Care teams have incorporated a digital tool designed to help patients with diabetes manage hemoglobin A1C. The tool is used in combination with four months of patient education sessions. Following the educational component of the program and for six months after, the tool helps patients maintain glucose control. Truwit notes that programs like these help improve the health of the patient population while keeping overall costs down for the health network.

**Paving the Way for Others**

The replication and learning from others, which is at the heart of McCutcheon’s Health Employer Exchange, ultimately will help move the industry farther away from fee-for-service and closer to value-based care. The systems in the HEE are considering an annual colloquium to share results and lessons learned from their work in improving care and reducing costs.

Intermountain’s Moore acknowledges it is the larger systems that must be the ones to lead the way in the pursuit of and transformation to value, especially in a financially stressed industry like healthcare.

“At Intermountain we recognize that many of the health systems and small hospitals, particularly rural hospitals, are really operating on thin margins, and that makes it a difficult time to walk away from potential revenue or income,” she says. “We’re trying to forge ahead with bold moves that we hope make that journey easier for others.”

And that “C” grade Jefferson College of Population Health’s Nash gave the industry back in 2016? Today he says it’s more like a “B” or “B-plus.”

“We have made progress, especially in the last three years,” he says. “Ten years ago, when we opened this school, there wasn’t even a textbook for what we were doing. Now there are 12 or 14 schools and universities that call themselves population health, and there are a score of medical school departments of population health.”

In addition to making progress, the field’s attitude also has evolved over the last few years, with many now acknowledging this is the right direction.

“I think it’s going to pay off if we all make this leap,” Moore says. “It’s going to be the right thing for patients, it’s going to be the right thing for our communities, and it will work out for health systems in the long run.”

Jessica D. Squazzo is a Chicago-area-based writer and editor.
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Health systems—large, small and in between—across the country are proactively addressing societal issues that affect the health of their communities and patient populations. Access to housing, healthy food and mental healthcare are increasingly seen as crucial to improving health. And, as healthcare shifts to a value-based model, these initiatives, which top leadership drives, have the added benefit of potentially improving the organizations’ bottom lines.

The following are five examples of hospitals and health systems who have invested in community health and are making a measurable impact on the wellness and stability of their patients.

**Kaiser Permanente**

“The interesting part of focusing on housing and homelessness is that there is no silver bullet,” says John Vu, vice president of strategy for Kaiser Permanente, Oakland, Calif. The largest managed care organization in the United States, Kaiser Permanente sees the challenges and disruptions of those issues from the front lines, in particular with the housing crisis in the Bay Area. Kaiser has launched several initiatives, across the country and at home, to address the needs of the homeless and lack of housing.

In partnership with Enterprise Community Partners, Columbia, Md., a nonprofit organization that works with partners nationwide to finance, build and advocate for affordable housing for low- and moderate-income families, Kaiser has established two major funds.

RxHome is a national low-interest loan fund available within Kaiser’s markets to developers of affordable housing. Housing for Health Funds matches investments from other healthcare systems, nonprofits and organizations committed to affordable housing.
Caring for the Vulnerable
Confronting Social Determinants of Health Improves Outcomes

RxHome’s focus in the Bay Area is on preserving existing affordable housing by protecting housing units and buildings in neighborhoods on the verge of gentrification. “Could we work with affordable housing developers to acquire those buildings and protect them and maintain the affordability for generations to come?” asks Vu. The effort to do so is certainly under way.

Currently, there are up to six deals across the Bay Area to purchase and preserve housing. Those include an 85-unit building, senior housing and a long-term goal to build 2,000 units over the next few years. Other industries headquartered in areas facing severe housing issues, including Microsoft in Seattle, have taken notice of RxHome’s initiative. “We are seeing some momentum building as others are jumping into this in big ways,” says Vu.

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Northwell Health
Northwell Health is New York State’s largest healthcare provider and routinely calculates a clinical risk score for patients. Those with chest pain, for example, are categorized as being at higher risk for a heart attack if they also have high blood pressure, and measures are taken to address those factors. “Now,” says Ram Raju, MD, FACHE, senior vice president and community health officer for Northwell, “we are creating risk scores based on social determinants of health because we know that outcomes are determined approximately 20% by clinical care and 80% by nonclinical factors, such as socioeconomic and environmental issues.”

Patients are asked 15 questions, and the answers are processed through an algorithm that creates a social vulnerability index, which indicates social risks that may be relevant to them. That information is then processed through NowPow, a platform that connects patients to social service or community-based organizations addressing their particular social issues, such as transportation, food, public safety, mental health, based on patients’ ZIP codes.

Food insecurity is an issue in many of the communities that Northwell serves, and a pilot program has begun in which patients are given a food prescription—in addition to their medication—that corresponds with their condition. Patients stop at Northwell’s Food Farmacy in the lobby of the hospital, and their food prescription is filled with free, fresh food. They also receive nutritional counseling. Patients unable to carry the food home themselves receive their filled food prescription through a community-based organization, Long Island Cares, which delivers the food to their homes.

Northwell’s efforts around food extend to inpatients and employees, as well. A Michelin Star chef was engaged to revamp the hospital’s food. Healthy food is now attractive and tasty food, too, and the same menu is used in the hospitals’ cafeterias. “That was a big hit,” says Raju. “And our patient satisfaction scores went up, too.”

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AMITA Health
AMITA Health, Lisle, Ill., is part of the Chicago HEAL (Hospital Engagement, Action and Leadership) Initiative, a consortium of almost 30 hospitals and public health departments throughout the Chicagoland area.

The collaboration has enabled organizations to specialize in various areas, and AMITA, as the largest behavioral health provider in Illinois and among the top 10 nationwide, was well poised to address that issue innovatively, and effectively.

“ ” says Will Snyder, senior vice president and chief advocacy officer for AMITA, and an ACHE Member.

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“The interesting part of focusing on housing and homelessness is that there is no silver bullet.”
—John Vu, Kaiser Permanente
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AMITA adopted an eight-hour certificate training program called Mental Help First Aid, which offers training on identifying and understanding different mental health conditions, how to identify and engage sufferers and connect them with appropriate resources. “There’s a big difference between somebody who is depressed and somebody who suffered from schizophrenia,” says Snyder. “Knowing the difference in how those symptoms present is really important.”

AMITA recognized that as many community partners as possible needed to be engaged, and it created partnerships with the Chicago public library system, the YMCA and others. To-date, more than 2,000 people have received the training.

Referring those with less obvious, though equally debilitating issues, such as depression, to available and nearby resources, is also a crucial component of effectively caring for behavioral health patients. “I think that in the past health systems have not made it clear how you access behavioral health services,” says Snyder. “Over the last three or four years we have really seen that change, and I think the solution, and potential, in a community-based setting is that people don’t have to leave their neighborhoods. They can go to a library, a church or a community center to get the resources and services they need.”

Now, numerous hospital systems in the HEAL Initiative have implemented Mental Help First Aid or are investigating it as a curriculum to offer themselves.

The University of Illinois Hospital & Health Sciences System

In 2015 the University of Illinois Hospital & Health Sciences System, which is also part of the Chicago HEAL Initiative, launched its Better Health Through Housing program, which identifies the ED and behavioral health patients who are chronically homeless and helps them find supportive housing. The program uses the Housing First model, which places no preconditions, such as being on medication or in treatment, on potential participants.

“The magic of the whole thing is that once you put somebody into housing, they stabilize and get to a place where they can manage their own lives,” says Stephen Brown, director of preventative emergency medicine. And retention rates prove his point. Under previous guidelines retention was around 20 percent, but now it has flipped and is steady at 80 percent.

Another factor in the program’s success is that patients are offered a choice in where they live. In partnership with the Center for Housing in Help and the AIDS Foundation of Chicago, patients are directed to approximately 4,000 units scattered throughout Chicago.

The University of Illinois Hospital & Health Sciences System experienced an almost 60 percent drop in IP utilization, and an almost 70 percent drop in ED utilization, and those rates have remained consistent.

“We acknowledged our health equity mission here as one of two public hospitals in the city of Chicago,” says Brown. “Our CEO (Michael B. Zenn, an ACHE Member) said, ‘This is the right thing to do.’ This initiative has given us an opportunity to examine a very vulnerable population, patients who are most at risk for early death, bad outcomes and who
suffer as the result of chronic homelessness and associated illnesses.”

**Arnot Health**

Smaller health systems have launched ambitious initiatives, too. Arnot Health, Elmira, N.Y., a three-hospital system, participates in a New York State initiative for Medicaid patients that identifies “high-utilizers,” patients with four or more inpatient visits within a 12-month period. Its IT department developed an automated alert that uses data analytics to identify these patients and intervene when they visited the ED or are admitted to one of the hospitals.

“We identified that when patients are discharged, they’re often on their own to figure out how to get their meds, how to get transportation to their primary care provider and set up appointments,” says Pallavi Kamjula, MD, medical director of care coordination. “We felt that if we identified these patients in the hospital and helped keep them in their homes before we connected them to a primary care physician, you might make an impact.”

Rose Barnes, RN, visits with patients in their homes to assess the environment as part of Arnot’s Transition to Home program. Along with a hospital resident, “We go over their discharge medications to make sure that they match with what they have in their home,” she says. “We also educate them on appropriate food choices if they are diabetic, for instance, and also, for patients with chronic obstructive pulmonary disease, that they know how to use their inhalers, including which ones are for immediate needs and which ones are for daily use.”

Arnot has impacted the community on a micro level, as well. Another team member, Sue McCabe, RN, is a congestive heart failure educator. She visited local grocery stores to shop for low-salt foods and found that they were unmarked, inaccessible and seldom at eye level. She contacted nearly every grocery store manager in the area and received a reply from only one. She met with the manager, and now that grocery store is in the process of rearranging its aisles, with one dedicated to low-sodium food items.

**The Future of Social Programming on Population Health**

Increasingly, hospitals, health systems and other major healthcare organizations are realizing the impact of social and societal factors on overall population health, and are taking action to address and mitigate these ill effects. This key shift comes as the result of extensive population health research, as well as a corporate demand for more efficient and cost-effective initiatives to address the growing need for preventive health offerings.

Investment in community health, even on a smaller, ad hoc level, can have a measurable impact on the wellness and stability of the patients it serves. Education, opportunity and accessibility are hugely important factors in the overall health of local communities, and as these programs work to address the unfilled needs of their populations, their success could help encourage the development of similar initiatives, and therefore improved population health, in additional communities across the country.

*Brian Justice is a freelance writer based in Chicago.*
Updated Ethics Self-Assessment Addresses Current Issues

Revisions to the tool strengthen healthcare leaders and their organizations.

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Our Code of Ethics is a defining document for the organization, our members and the profession; so much so that the Code is a requirement of ACHE membership.

The Ethics Self-Assessment—included in this issue on Page 60—is an invaluable tool available to ACHE members. Based on the Code of Ethics, the self-assessment is used to evaluate leadership and ethics-related actions, and to address potential red flags identified in the process.

The self-assessment gives life to the Code of Ethics and functions as a checklist of best practices in different areas. Perhaps more importantly, the assessment provides a framework for individuals to evaluate the frequency of their own action in demonstrating ethical behaviors and in relationship with others.

Each year, ACHE’s Ethics Committee reviews and considers revisions to the Ethics Self-Assessment. Typically, these revisions consist of minor changes, but in 2018, the committee added eight new statements to better reflect some of the larger issues at stake in healthcare today (see box). Following are summaries of the issues that prompted the revisions.

Recent Additions and Changes to the Ethics Self-Assessment:

- I take responsibility for understanding workplace violence and take steps to eliminate it.
- I engage in collaborative efforts with healthcare organizations, businesses, elected officials and others to improve the community’s well-being.
- I seek to identify, understand and eliminate health disparities in my community.
- I seek to understand and identify the social determinants of health in my community.
- I am committed to eliminating harm in the workplace.
- I am committed to helping address affordability challenges in healthcare.
- I am sensitive to the stress of the healthcare workforce (including physicians and other clinicians), and take steps to address personal wellness and professional fulfillment, such as incorporating these issues in employee and physician satisfaction/engagement surveys.
- I take steps to understand my workforce as it relates to safety, stress and burnout, and consider the impact of those who are in positions of authority (including executives and physicians).

Workplace Violence

The only change within the leadership category pertains to an executive’s responsibility to understand workplace violence and take steps to eliminate it. The addition of this statement stems from increased violence in the workplace.

Community Health

Three new statements were added to the community section of the relationships category to better reflect that healthcare organizations are responsible for the health of the communities they serve.

Patient Safety

In the section pertaining to patients and their families, the committee introduced two new statements related to articulating executive commitment to eliminate harm in the workplace and address affordability challenges in healthcare.

Burnout

Finally, the committee added two new statements under the colleagues and staff subcategory to focus on the need for greater awareness of stress among the workforce—including the impact of those in positions of authority—and to take steps to address the personal wellness and professional fulfillment of employees and physicians.

ACHE is committed to supporting its members and the important work they do with tools like the Ethics Self-Assessment, Code of Ethics and other resources that comprise the ACHE Ethics Toolkit. Visit ache.org/EthicsToolkit to access these resources.

Sinde A. Hahn, FACHE, CAE, is senior vice president, Department of Member Services, ACHE, and its chief ethics officer.
The Innovations of Change

We’re passionate about innovations that have impact. Which is why we are applying artificial intelligence and machine learning technologies to identify patterns and anomalies, and inject more “intelligence” into the healthcare ecosystem. For example, by integrating AI into the claims management and payment processes, we can help improve efficiency, reduce costs, and optimize cash flow. It’s one more way we are helping change healthcare for the better.
Cultivating Relationships Using Baldrige

A culture of trust leads to success for one Alaskan health system.

Alaska’s Southcentral Foundation has received the Malcolm Baldrige National Quality Award not once but twice, in 2011 and 2017. How did the Anchorage-based nonprofit manage to attain and then duplicate this coveted honor?

President and CEO Katherine Gottlieb, DPS, LHD, provided a short answer and a longer explanation to this question during the 2019 Congress on Healthcare Leadership Masters Series Session “Quality and Process Improvement,” which also featured Adventist Health Circle President and CEO Kathryn A. Raethel, FACHE. (Raethel describes her hospital’s Baldrige journey in the May/June 2018 issue—Page 56—of Healthcare Executive.)

Gottlieb first listed the impressive results that Southcentral Foundation has achieved, including:

- Decreasing ED visits and hospital admissions by 36 percent between 2000 and 2017
- Achieving 75 percent to 90 percent on many Healthcare Effectiveness Data and Information Set outcomes
- Attaining 97 percent patient satisfaction and 95 percent staff satisfaction scores

“We’re driving down costs while providing care to 65,000 Alaska Native and American Indian people,” Gottlieb said.

The rest of her presentation focused on the overarching management approach that Southcentral Foundation adopted to achieve and sustain these stellar results, building a culture of trust based on relationships. Here are three strategies Gottlieb highlighted for attaining buy-in and trust from patients/customers and employees:

Incorporating the Customer Voice

Southcentral Foundation is unique in that the health system is owned by its native community. Under the 1975 Indian Self-Determination and Education Act, Native American tribes can choose to separate from the federally controlled Indian Health Services and instead receive government funds to operate local healthcare services designed to meet the needs of their communities.

“The Alaskan Native people chose to assume responsibility for their healthcare,” Gottlieb said, which led the provincial tribal authority, Cook Inlet Region Inc., to establish Southcentral Foundation. This turn of events provided a unique opportunity to completely redesign the local health system to reflect what mattered to the Alaska Native and American Indian patient population who live in and around Anchorage or in rural villages accessible only by plane or boat.

An extensive needs assessment was conducted in 1993, and residents were invited to share—via surveys, focus groups and tribal meetings—what they wanted in their revamped health service. “Our customers/patients said, ‘We want everything changed,’” Gottlieb stated. “They said, ‘We want new facilities, we want our own primary care providers, we want people who will serve and provide care in culturally appropriate ways.’ So … we started changing everything.”

The result is the Nuka System of Care, which is a culturally oriented, holistic approach to care that emphasizes spiritual and emotional wellness, in addition to physical and mental health. Family and community health are also emphasized. Patients are assigned an integrated primary care team that coordinates their needs. In addition to providing

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comprehensive medical care, Southcentral Foundation offers non-traditional health services, including learning circles, where tribal members can gather in small groups to achieve wellness goals; a traditional healing clinic staffed by tribal doctors; a wellness center that offers healthy cooking classes; and exercise equipment and classes.

To drive home the fact that Southcentral Foundation is owned by local residents, “we quit calling our patients ‘patients,’” Gottlieb said, “and we began calling our patients ‘customers.’”

Over the years, listening to the customer’s voice has become so ingrained that the organization has begun to address customer concerns before market research identifies these issues. “We’re in sync, which is great news,” Gottlieb said. For example, a recent needs assessment revealed that alcohol, drug and tobacco use was a top health concern in the community. One step ahead of the research, Southcentral Foundation had already begun developing a new addiction program.

Empowering Employees

To encourage employees to not only identify but also follow through on creative ideas for improving customer relationships, Southcentral Foundation rolled out a decentralized approach to innovation.

One component is the organization’s operational principles, which is a set of 13 statements that spell out the word “relationships.” “If you have an idea for a new initiative,” Gottlieb said, “we are going to first line it up against our operational principles. Does it foster customer-owner relationships? Is there an emphasis on wellness? Is it location friendly? [We go] all the way down the list [of principles].”

The Nuka System of Care is a culturally oriented, holistic approach to care that emphasizes spiritual and emotional wellness, in addition to physical and mental health.

A second component is the organization’s functional committee approach. All employees are invited to sit on one of four functional committees: operations, process improvement, quality assurance or quality improvement. Employees can present innovative ideas at any time to these committees for approval, assuming the idea reflects strategic priorities and fits in the budget. “If you have determined that something works better in your department, it can move through committee and take off on its own, without having to go back to executive leadership,” Gottlieb said.

Storytelling and other relationship-building strategies that Southcentral Foundation deploys help keep employees and customers emotionally and physically resilient. “Knowing each other keeps us healthy,” Gottlieb said.

Maggie Van Dyke is a freelance writer and editor based in the Chicago area.
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Putting Patient-Centric Care Front and Center

Integrated care model helps reduce variability and improve quality.

“Patient-centric care can’t just be lip service. Organizations need to start by believing in patient-centric care, but then also have a plan to put it into action.”

—Andy Mulvey, MD, FACEP
Vice President, Clinical Sales and Strategy
Envision Physician Services
Indianapolis

Those working in today’s healthcare industry understand their mission is to serve patients and communities. But what if putting the patient first were more than just a mission? What if this mindset were integrated into everything a healthcare provider did, from the time a patient walked in the front door of the ED to the time that patient was discharged from a hospital stay?

When patients are at the center of a hospital or health system’s entire operational process, the value the organization receives in return—from both nonfinancial and financial perspectives—can be vast, extending beyond improved patient experience. One particular patient-centric care model achieves such benefits through its unique approach of integrating emergency medicine and hospital medicine seamlessly. This model is proving to be a win-win-win for patients, clinicians, and healthcare systems and hospitals alike and is leading to improved outcomes and quality and even increased market shares.

From Door to Discharge

With nearly 70 percent of all hospital admissions originating from the ED, a patient’s experience often starts with emergency care and ends with care on the inpatient side, according to research by the RAND Corporation. As such, better integration between the two departments must be a critical component in the effort to improve care outcomes and the patient experience.

“There is real value behind having continuity between emergency medicine and the inpatient or hospital medicine side,” says Andy Mulvey, MD, FACEP, vice president, clinical sales and strategy, Envision Physician Services. “The idea behind integrating emergency medicine and hospital medicine is that less-complicated patient handoffs and improved communication help standardize care and reduce some of the variability that can occur over the course of a patient’s hospital stay.”

Improved integration, communication and standardization of care are at the heart of the Envision Physician Services EM/HM Better Together integrated patient care model. Mulvey describes it as a door-to-discharge hospitalwide flow model that considers the patient experience at every step. The concept, he says, is that through all stages of the patient’s journey—from the ED to inpatient stay—all processes must answer “yes” to this question: Is this something that improves the patient’s quality of care and his or her patient experience?

The model operationalizes patient-centric care by implementing concrete plans on the ED and hospital medicine sides for improving the patient experience. “Patient-centric care can’t just be lip service,” Mulvey says. “Organizations need to start by believing in patient-centric care, but then also have a plan to put it into action.”

The EM/HM Better Together integrated patient care model addresses common challenges in the front-door part of a patient’s experience (coming through the ED) and on the backdoor side (the inpatient stay or hospital medicine), according to Mulvey. Some examples include the following:

**EM Challenge**: Long patient wait times to be seen by a provider
**Solution**: Immediate bedding of patients (seeing a provider within 15 to 20 minutes of arrival) and bedside triage

**EM Challenge**: Long length of stay in the ED, causing patient frustration
**Solution**: More parallel workflow and reduced turnaround times for lab and imaging
**HM Challenge**: Messy patient handoffs and unclear gap orders

**Solution**: Improved communication between emergency medicine and hospital medicine clinicians, including a single point of contact, creates a seamless transition from the ED to the inpatient side of the hospital and uninterrupted continuity of care.

**HM Challenge**: Long wait times to see a physician once admitted to the inpatient side

**Solution**: ED physicians’ ability to initiate patient orders eliminates delays in patient care on the hospital medicine side.

**Patient-Centric Care’s Full Impact**

Facilities that have implemented the patient-centric care model have seen improvements in clinical outcomes, patient satisfaction, staff satisfaction and increased market share, among other benefits. One facility that implemented the EM/HM Better Together model experienced dramatic improvements in its left-without-being-seen numbers and reduced patients’ lengths of stay, according to Mulvey. This resulted in increased capacity in its ED and inpatient sides and helped to eliminate ED boarding and lower costs due to reduced lengths of stay.

The facility also adopted a split-flow model in its ED that allowed lower-acuity patients to be seen by advanced practice providers, while patients requiring more acute care could be seen by the ED’s physicians. In addition to improving patient flow and experience, these patient-centric changes also resulted in a surprise benefit: increased volume in the ED based on increased capacity.

Prior to implementation of the EM/HM Better Together model, the facility’s ED had approximately 30,000 to 35,000 visits per year, or about 100 patients per day. “Over the course of two to three years, we saw volumes go all the way up to 50,000 visits—in the same physical plant, not a new ER,” Mulvey says. He attributes this growth to patients who were perhaps avoiding the ED because of the way it was run previously but who were impressed by the changes made.

“Once it became more patient-centric, this became their new location for care,” Mulvey says. Today’s savvier patients are expecting more from their care, and they have more options than ever when it comes to choosing where they receive that care. “In the old days, hospitals could maybe be the only shop in town,” Mulvey says. “Now we have microhospitals, urgent care centers and perhaps three different facilities within a few miles of each other, so you really have to be able to differentiate yourself in a competitive market to capture patients or keep your market share. Patients are smart; they are going to go where they will receive the best care for themselves and their family.”

**A Win for Patients and Staff**

While a patient-centric care model that integrates emergency and hospital medicine has clear benefits for patients, it also has been popular among clinical staff. Mulvey says that often, the perception is that when an organization makes changes to operations in a department such as the ED, the clinical staff will be reluctant or push back. While this may happen to some extent, the reality, Mulvey says, is quite the contrary.

“We find that when you move to an integrated patient-centric model for care delivery, the staff really appreciates it,” he says. “It’s a fun environment to work in. Your patients are happy. The efficiencies of the department are recognized, and that has added benefits for staff and providers. And, most importantly, it really impacts the quality of care delivered to our patients.”

For more information, please contact Envision Physician Services’ Business Development team at onesolution@shcr.com or 877-910-4993.
Increasingly, healthcare facilities are looking outside their field for best practices that can be used to improve various aspects of patient care. The Schuylkill County VA Clinic in Pottsville, Pa., looked to Disney for inspiration to take the patient-centered medical home model to the next level.

**Disney Inspiration and Innovation**

Though the patient-centered medical home model is not new, integrating this model of care with Disney’s on-stage, off-stage concept is an innovative way to approach healthcare facility design and operations.

Being on-stage means whenever employees are visible to or interacting with customers, they must completely embody their character, serving as friendly and helpful brand representatives and putting the customer experience first. When they are off-stage—say, in the break room—they may remove their costume, eat and rest.

The Veterans Health Administration considered this Disney concept when it constructed the Schuylkill County VA Clinic, which opened in February 2018.

**On-Stage Patient-Centered Care**

The Schuylkill County VA Clinic has a unique design. The patient pathway, or the on-stage area, is situated around the outer hallways of the clinic and consists of the registration/check-in desk, the waiting area, exam rooms and a space for shared medical appointments.

The design puts patients at the center of care by bringing all services—including labs and ECG testing—directly to them in their exam room. This approach allows providers to tailor the delivery of primary care and specialized services.

Exam rooms accommodate scooters and larger wheelchairs, and are large enough for veterans to bring their family or a caregiver to an appointment.

The on-stage area has access to natural light and facilitates a clean, quiet and comfortable experience for patients, and a calm and healing environment.

**Off-Stage Team-Based Care**

The staff work area, or off-stage area of the clinic, is located at the center of the building. The staff work area features open office spaces where integrated teams of caregivers can collaborate.
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Each patient is assigned a four-person care team made up of a provider, nurse care manager, clinical associate and administrative associate. These core groups frequently work with extended members of the team such as pharmacists, social workers, dietitians and behavioral health providers. The open layout of the work area supports the patient-centered medical home model by bringing professionals from across the continuum together to provide more coordinated, comprehensive care.

The clinic’s setup creates a collegial space for teams to consult one another about their patients’ care, prepare warm handoffs and make decisions in real time, all of which improves patient flow and other efficiencies.

The most up-to-date technology—including a fully integrated medical record, patient-secured messaging technology and competency-building training modules—support staff in a quiet and engaging workspace. Huddle spaces with whiteboards are great locations for teams to kick off the workday. Commonly used supplies are stored near the off-stage area, with access controlled through security and privacy improvements.

**Design Objectives for Access and Healing**
The Veterans Health Administration also identified design objectives to improve access to care and ensure the space can adapt to changing requirements while promoting access and efficiency. These objectives included:

- Standardizing room designs to support virtual/telehealth delivery.
- Providing space for shared medical appointments conducted for cohorts of patients with chronic diseases.
- Supporting a modular approach to overall clinic design and space planning. All spaces can adapt to future needs with minimal construction.

Additional features of the clinic include ceiling-mounted computers that better facilitate face-to-face
interactions between the provider and the patient better than traditional wheeled computer workstations; the removal of the glass barriers typically found between the receptionist and the patient and added partitions between each receptionist area to ensure patients’ auditory privacy. The message of all these elements is clear: You are welcome here, and we respect your privacy.

These design elements highlight the essential connection between function and form, optimizing the space to enable the healthcare team to provide outstanding clinical care. In addition, the model allows for adapting to varying needs from clinic to clinic. Some of these primary care clinics provide physical and occupational therapy services, others provide optometry and audiology. Ultimately, the design and care model of the Schuylkill County VA Clinic has set the standard for the VA’s primary care clinics; every new clinic built will follow this structure.

As healthcare moves toward value-based care, these design elements and processes for care delivery will likely become increasingly present in healthcare organizations outside the VA as well.

Patient and Care Team Feedback
This on-stage, off-stage framework emphasizes the provision of care that is accessible, timely, coordinated, continuous, comprehensive and compassionate. The Schuylkill County VA Clinic facility and care team put primary care and the medical home at the foundation of healthcare delivery, with the patient at the center of the healthcare team. It has become the initial design standard for creating functional, efficient, nurturing and pleasing environments, and it will continue to evolve.

The Schuylkill County VA Clinic was the first of several clinics designed using this approach, which has been shown to engage patients on many levels. As patients settled into this new look, many contributed mementos and personal art that have helped to make these clinics their own.

Patients routinely give feedback on surveys stating, “Wonderful place, wonderful care, wonderful people!” and “Very impressive, beautiful clinic! Great care!”

Patients aren’t the only people pleased with this innovative clinic. The staff has welcomed this highly functional work environment. They see the design of the clinic as a big improvement in patient and staff privacy and safety.

One Schuylkill County VA Clinic physician assistant, Andrew M. Knepp, remarked, “The setup of the clinic is great. The veterans are very happy and that makes us very happy.”

Karen Bondura is clinic manager of the Schuylkill County VA Clinic in Pottsville, Pa. (karen.bondura@stginternational.com). Mary-Ellen Piché, FACHE, is a consultant and ACHE Faculty Associate (picheme@gmail.com) who teaches the seminar “Leading for Change: Creating a Humanistic Approach for Patient, Family and Staff Engagement,” offered at the New York Cluster, July 29–Aug. 1.
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Private equity investment in U.S. healthcare plays a formidable role today and, in all likelihood, will play an even greater role tomorrow.

Public policy enables private equity investors to create opportunities in the U.S. healthcare system. In many cases, these funds facilitate the creation of new sectors like micro-hospitals, physician practice management and others, thereby fueling competition for traditional players in the system such as hospitals, physicians and post-acute providers.

Unlike venture capitalists, private equity investors are not interested in startups or early-stage companies; they recognize that 70 percent of those businesses do not launch. Each private equity fund has a unique portfolio based on its investment thesis. For example, some specialize in a sector or industry, while others are more diversified. Some primarily focus on U.S. markets; others invest in global opportunities. Often, investors partner with companies and other funds to acquire equity stakes in businesses; sometimes they go it alone.

The Scope of Private Equity Activity in Healthcare

Overall, private equity funds raised $714 billion last year—the third most lucrative year on record. Since 2014, investors have raised $3.7 trillion and have $2 trillion on hand to invest in other opportunities they discover.

In 2018, there were 715 private equity deals in the healthcare field for a combined value of $103.72 billion, up from 709 deals worth $88.87 billion in 2017, according to a December 2018 article in Forbes. Experts predict there will be fewer but bigger deals in 2019. These deals will affect each sector in healthcare.

Increased Activity in 2019 and Beyond

There are two forces driving private equity investors’ confidence in the healthcare field: federal policy and public concern regarding health costs.

Federal policy is favorable to private equity investment. The federal government directly controls more than 40 percent of total healthcare spending. Medicare, Medicaid and other government healthcare programs consume 29 percent of the total federal outlays, and they are expected to increase 5.4 percent annually through 2026. Complicating matters, the trillion-dollar federal deficit from fiscal year 2017 looms as an important campaign issue in 2020. The Trump administration is pursuing strategies to lower spending in Medicare, Medicaid and other health programs to lower the deficit.

The public is concerned about health costs and open to solutions.

A 2019 Gallup and West Health survey of U.S. adults shows the public is more concerned about medical bills and out-of-pocket healthcare costs than housing, food and other essentials. Consumers think health costs are too high and blame hospitals, physicians, insurers and drug companies. They want holistic healthcare with predictable prices and convenience, and insurance that is understandable and affordable.

There is scant evidence that ownership status plays a major role in...
consumer choices in healthcare. Consumers believe quality and safety are adequate across the system, so they are willing to use providers who offer lower prices and better service.

**Implications for Providers**

In the U.S. healthcare industry, the discovery of new therapies, integration of information technologies and analytics, expansion of services via digital and telehealth, direct-to-consumer retail health, customized health insurance, professional services (e.g., behavioral health, physicians, dentistry) and development of hybrid care delivery models require capital to compete.

Operating margins alone are insufficient to fund growth in most healthcare sectors; they require the combination of debt and, in many cases, private equity investments. The reality is that every healthcare organization, large or small, is impacted by private equity’s increased role in healthcare.

For most healthcare providers, there is an imperative to increase both their scale of operations and scope of services. Therefore, partnering with, or competing against, private equity-backed ventures will be the norm in most markets. Healthcare leaders must recognize three realities as private equity takes center stage in reshaping the U.S. healthcare landscape:

- **Private equity is opportunistic.** Opportunities to improve the efficiency and effectiveness of U.S. healthcare are readily accessible to private equity. That is why more than one-half of private equity funds specialize in either healthcare or technology that offer strong growth, recession resistance and superior historical returns.

  But, the prospect of an economic downturn in 2020 means private equity will be more aggressive in its investments, pursuing healthcare sectors where margins are thin, regulatory compliance is manageable, demand is strong and growing, incumbents are vulnerable, and a scalable operating model is a strategic advantage.

- **Private equity is powerful.** Most private equity funds prefer a low profile. They guard the identities of their investors and prefer the spotlight to shine on their portfolio companies. Some are better known than others, but in healthcare, they are powerful. Many big names in investment banking have deployed billions in healthcare.

  Private equity is here to stay in healthcare. It is essential that providers clearly understand and anticipate its expanding role and implications for them at the local level. ▲

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Boosting Clinical Knowledge

Why executives need to learn about the clinical core.

As healthcare organizations strive to become more patient-centered, the composition of administrative teams and the expected scope of leaders’ knowledge has shifted as well.

Leaders who possess a strong business background have always been crucial to the success of a healthcare organization. That is why many clinicians pursuing a career pathway in administration are now returning to the classroom to strengthen their business acumen, including financial and operational skills.

But what about leaders who already have experience and success related to the administrative aspects of the business with little to no clinical experience? With increasing focus on the patient experience and patient-centered care, basic knowledge of clinical processes and clinical care delivery is becoming increasingly important for nonclinician executives looking to advance in their careers and achieve excellence in healthcare management.

Nonclinician executives who struggle to communicate with clinicians, and who struggle to understand and support clinical processes with resources, will face fierce competition for jobs. Not only that, but leaders who are unfamiliar with clinical core processes, interprofessional team care delivery, and the irregularities and nuances in individual patient care may find it difficult to improve clinician-executive relationships, limiting the organization’s ability to provide the best patient care experience.

Kenneth R. White, PhD, RN, FACHE

Driving Factors of Shifting Expectations

Within the past 20 years, the profile of senior administrative teams began to include more CNOs, CMOs and other similar positions with formal education and experience in both the clinical and business domains of healthcare. Listed below are the driving factors behind the increasing importance of the clinical core to the success of healthcare leaders.

Quality and Safety

As the healthcare field transitions to value-based care, healthcare delivery organizations are facing higher levels of accountability related to patient care quality and outcomes. The paradox is that some of the administrators responsible for these processes and results do not have the clinical knowledge or licensure to confidently evaluate the care processes and outcomes.

With reimbursement increasingly being tied to quality metrics and outcomes, it is critical for leaders to have a solid foundation in the clinical core, be well-informed of clinical operations, and know strategies to improve these processes and enhance clinical and safety measures.

Professional Ethics

Healthcare leaders who prioritize patients over financial returns and fully understand the clinical consequences of their decisions, are unlikely to suffer the consequences, including personal and professional penalties and even possible legal action.

When leaders support their decision making with sound clinical best practices, patient care will improve, and those leaders will elicit the trust of their peers, staff, patients and community.

Increased Regulation

Now more than ever, federal, state, local and private regulatory agencies consider the interests of patients in their oversight of healthcare delivery organizations. Part of that oversight includes ensuring professional behavior and organizational accountability related to patient care.

Regulatory bodies and other healthcare organization stakeholders—including hospital boards, employees, patients and community members—are expecting more transparency from their leaders regarding what is being done to prioritize patient interests and guarantee regulatory compliance.

Leaders must be able to understand clinical care information, and question and support it.
**Shoring Up Knowledge of the Clinical Core**

What type of knowledge is needed for a greater appreciation and understanding of the clinical core of healthcare leadership, and how can executives build their knowledge in these areas?

Healthcare leaders are pulled in many different directions and much is expected of them. Knowing where to begin to bolster knowledge of clinical processes can seem daunting, but there are numerous resources available.

For instance, the American College of Healthcare Executives and the Healthcare Leadership Alliance published the Healthcare Executive 2019 Competencies Assessment Tool. The tool lists “knowledge of the healthcare environment” as one of five critical domains of leadership.

Subcategories of this domain include knowledge of healthcare systems and organizations, healthcare personnel, the patient’s perspective, and the community and the environment. The tool is a great place for leaders to assess their expertise, identify competency gaps and find educational resources to strengthen their skills.

Nonclinical leaders should also pursue education that covers:

- An overview of the different patient care models and how interprofessional teams contribute to patient care
- Basic tenets of patient satisfaction, and clinician satisfaction and engagement
- Organizational and managerial practices that attract and help retain high-quality clinicians

Beyond attending formal continuing education programs, there are several actions administrators can take to build respect and knowledge of the clinical enterprise. Tips include:

- **Making rounding a priority.** Rounding is not just about learning about what clinical teams do and their checklist of responsibilities, it’s about having a genuine interest in their work. For rounding to be effective, leaders need to go beyond the basic question for clinicians of “What do you do here?” and ask, “What drove this decision?” “What are your competing priorities?” “What are the barriers to and facilitators of the best possible care?” and “How do you work together as a team with your patients to improve outcomes?”

- **Shadowing clinical teams.** Too often, leaders view shadowing a clinician as a one-and-done deal. Instead, administrators should continuously seek out new opportunities to learn about the challenges and rewards of being a trauma surgeon, cardiologist, pediatric nurse or palliative care nurse practitioner.

- **Seeking interprofessional opportunities for improvement.** The more that nonclinicians work alongside clinicians, the quicker they will learn about ways to improve patient care processes and outcomes and get a glimpse into the clinical decision-making process. To this end, administrators will be better prepared to offer support to integrate clinical and nonclinical knowledge and resources in interprofessional process improvement teams and task forces.

Administrators are striving to make healthcare organizations more patient-centered to add value for customers. One way administrators can add value to their organization is by honing the skills and abilities to understand, appreciate and learn from front-line care delivery teams about the complexities and rewards essential to delivering the highest quality care.

Kenneth R. White, PhD, RN, FACHE, FAAN, is the UVA Medical Center endowed professor of nursing, and associate dean for strategic partnerships and innovation in the School of Nursing at the University of Virginia in Charlottesville. He was also a recipient of ACHE’s 2019 Gold Medal Award.

**Editor’s note:** The ACHE Healthcare Executive 2019 Competencies Assessment Tool is available at ache.org/LeadershipCompetencies. The tool allows you to assess your skills in the five critical domains of healthcare leadership and suggests readings, educational programs, self-study courses and more to help you address knowledge gaps.
Finding the Right Governance Restructuring Role

Board leaders and executives must strike an appropriate balance in the process.

According to recent data from the American Hospital Association’s National Health Care Governance Survey Report, about two-thirds of all hospitals and health systems surveyed in 2018 reported engaging in governance restructuring within the past three years. Based on the survey questions, the types of restructuring in which they participated included changing the number of board committees, increasing or decreasing board size, enhancing the board’s skills and competencies, and clarifying authority between system and subsidiary boards (for systems).

What the report points to is that restructuring initiatives can help boards ensure their governance structures and practices are aligned with and supportive of the hospital or health system during the industry’s continuing transition to value.

A key success factor in any governance restructuring is ensuring the process is handled as a change management initiative that appropriately balances board and executive roles.

Typical Role Challenges

Although many of the recommendations provided may seem obvious to experienced CEOs, not all executives who are in charge of governance restructuring initiatives have the same level of expertise as a seasoned CEO. For instance, it is becoming more common for busy CEOs to delegate the support of governance to the chief strategy officer, COO, hospital president (within a system) or a board support professional. Although some of the individuals serving in these roles may have deep governance experience and know their board members well, that is not always the case.

An added complication is that not all executives fully appreciate that boards have a legal, fiduciary duty to ensure their own governance is structured and functioning effectively. Skilled executives who are accustomed to taking charge may inadvertently play too strong a role vis-à-vis board leadership.

One more potential challenge is that not all executives have led sophisticated change management initiatives such as a governance restructuring. Therefore, they may not recognize the importance of paying attention to small things such as who authors communication about the governance restructuring.

The recommendations in this column are intended to help executives who have less experience with governance and find themselves in a position of needing to support the board leadership’s pursuit of governance excellence.

A key success factor in any governance restructuring is ensuring the process is handled as a change management initiative that appropriately balances board and executive roles. Achieving this balance can be especially difficult if the executive leading the governance restructuring does not have extensive experience and expertise in governance.

Recommendations for Ensuring Appropriate Roles

Board leadership and the executives can set the appropriate tone in board restructuring efforts by ensuring the board chair sends the first memorandum...
announcing the governance restructuring. Similarly, board leadership should author other memos throughout the process.

It is wise for the board chair to work closely with key executives to select the individuals who will participate in and chair the process. For instance, if an ad hoc governance restructuring task force is created, the appropriate executive(s) and chair can ensure the task force includes individuals who have governance expertise and understand the organization and its strategy. It is also important that a board member, not an executive, chair the task force. Alternatively, the governance committee can lead the restructuring effort.

The committee or task force chair and key executives should co-design the task force or committee meetings; however, the task force chair should facilitate the meetings. Executives may have a part to play in the meetings, such as explaining the strategic plan, but the board leader should run the meetings to ensure it does not appear that management is controlling the process.

Likewise, board members of the committee or task force should play a role in any input or feedback sessions that are part of the process. Ideally, they would present the initial ideas and facilitate discussions about those ideas. Executives, such as the chief strategy officer and general counsel, might help explain the strategy or the current bylaws, but the board members should lead the stakeholder input meetings.

These are just a few ideas. By discussing their roles at the beginning of a governance restructuring process, board leaders and executives can ensure they strike the appropriate balance between the expertise of the executives and the involvement of board members. This partnership will likely result in greater acceptance of any governance restructuring recommendations.

Pamela R. Knecht is president/CEO at ACCORD LIMITED, Chicago, and an ACHE Member (pknecht@accordlimited.com).

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Learn more at ache.org/PostGrad
At your next leadership meeting, I challenge you to discuss this question: How is the team working with your CNO to improve patient safety and quality of care?

An estimated 60 to 80 percent of the clinical staff workforce reports to the CNO. Since these front-line staff are at the bedside 24/7, it is imperative for healthcare leaders to integrate nurse executives into the quality improvement conversation. However, CNOs often are not a part of the conversation. This makes little sense because nurse executives are significant drivers of your workforce’s pursuit of clinical excellence and organizational safety and quality, as evaluated through patient outcomes and accreditation surveys.

When Discipline Is Warranted

CNOs can use the following tests to determine whether discipline is appropriate:

- **Deliberate Harm Test**: Assess if the event or harm was intentional.
- **Incapacity Test**: Rule out ill health or substance abuse.
- **Foresight Test**: Answer the basic question, “Did an individual depart from agreed safe practices or protocols?” Protocols and procedures must be judged to see if they are:
  - Available
  - Intelligible
  - Workable
  - Correct
  - Used routinely
- **Substitution Test**: Question whether another person from the same professional group, with similar training and experience, would have behaved the same way in similar circumstances. This assessment also looks at mitigating circumstances.

The concept of high reliability is more than 10 years old but is still new to many organizations. Many nurses and other clinicians often mistakenly interpret high reliability to mean effective standardization of healthcare processes, when it is actually much more.

A safety culture can only be achieved when staff feel comfortable reporting adverse events and close calls.

High reliability describes organizations and industries, such as commercial aviation and nuclear power, that maintain extraordinarily high levels of safety and quality over long periods of time with no or extremely few adverse or harmful events, despite operating in very hazardous conditions. In healthcare, high reliability means that care is consistently excellent and safe across all services and settings.

CNOs who succeed at achieving high reliability have a real understanding of organizational culture and the human factors that contribute to a healthy work environment. They are able to build trust and encourage error reporting, free-flow
communication and a healthy work environment.

**Safety Culture Foundation**

High reliability cannot be achieved without a strong foundation of safety culture, which is the sum of what an organization is and does in the pursuit of safety. It is the product of individual and group beliefs, values, attitudes, perceptions, competences and patterns of behavior that determine an organization’s commitment to quality improvement.

As a healthcare executive, how can you encourage and support your CNO to strengthen the safety culture throughout all levels of your organization? One way is through the accreditation process.

The Joint Commission surveys organizations based on its standards; issues findings based on observations, practices and circumstances during the time of the survey; and provides a report to the organization to address deficiencies in standards or quality improvement opportunities identified during the survey. Nurse executives need to have a prominent role in each step of this process.

Though nursing staff are regularly involved in the preparation part of accreditation, once an accreditation survey is conducted and completed, the results often are not shared with front-line staff. This provides a unique opportunity for nurse executives to effectively communicate survey results, including any findings related to safety culture, discuss the organization’s progress on pursuing safety culture, and develop action plans and set goals for further improvement.

In addition to being active participants in the ongoing accreditation process, CNOs can improve cultures of safety by creating policies to measure it across their clinical staff. Including safety culture as a performance expectation for all staff helps establish and emphasize its critical role in achieving high reliability.

**Safety Culture: Who Is to Blame?**

A safety culture can only be achieved when staff feel comfortable reporting adverse events and close calls. Such reporting helps organizations address smaller problems before they magnify and cause harm.

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**The concept of high reliability is more than 10 years old but is still new to many organizations.**

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Nurse executives can work with the C-suite to support the idea that the system, not the person, often is to blame. All too often, healthcare organizations do not acknowledge that errors occur due to system process failures and instead blame individuals.

Though staff must take individual responsibility for their actions, they also need to know that leadership will listen and act when they voice a safety or quality concern. This is a central component of high reliability, and one that organizations often have trouble putting in place.

A reporting culture does not develop overnight, but there are a few building blocks that nurse executives are uniquely qualified to influence:

- **Establish trust.** For nurse leaders, this goes back to responding to any early warnings staff may have shared. This can prevent errors and send a clear message that no level of risk tolerance is acceptable.

- **Eliminate fear of punishment.** Reinforce the concept that reporting is really about uncovering system errors.

- **Examine errors, close calls and unsafe conditions.** Find the data in every event report, and use the numbers to identify patterns, outside factors, etc.

The good news is that high reliability is attainable. As more and more healthcare organizations advance on their high-reliability journey, The Joint Commission looks forward to continuing to collaborate with CNOs who are ready to join the quality improvement conversation. I could not be more ready or more proud to see my fellow nurses take on this important role. ▲

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Mark G. Pelletier, RN, is COO of Accreditation and Certification Operations and chief nursing executive at The Joint Commission, Oakbrook Terrace, Ill. (mpelletier@jointcommission.org).
The industry’s evolution to value-based care payment models has been a constant journey for many healthcare organizations for more than a decade. Healthcare providers across the wide spectrum of the field have been learning as they go, building on successes and failures. But when it comes to evaluating the industry’s progress so far, if you’ve seen one successful value-based care model, it just means you’ve seen one successful value-based model. That’s because some organizations, states and industry sectors are further along than their counterparts or have unique factors affecting these markets.

The movement toward value-based care and population health management, or community health management, is also incredibly local in its orientation. The ubiquitous bumper sticker phase sums it up nicely: “Think globally, act locally.” With that in mind, CEOs should not only approach value-based care initiatives with the big picture in mind but also with an internal focus on what fits their organization’s unique characteristics such as size, location, culture and payer mix. Today’s healthcare CEOs also play a critical role in courageously leading their organizations into these new, vital frontiers.

**A Multidimensional Work in Progress**

Howard University Hospital is an academic training, urban hospital located on the campus of and owned by a historically black college and university. It is the only facility of its kind in the United States. Howard also serves as the primary essential-access hospital in Washington, D.C.; approximately 75 percent of the district’s vulnerable population seeks care at Howard. With these distinctive attributes in mind, Howard has embarked on several value-based care and community health initiatives, including engaging in discussions with managed care organizations and configuring them to be more integrated so they can build the infrastructure needed to support these goals.

As an essential-access nonprofit hospital, Howard’s payer mix is primarily governmental, with over 85 percent comprising the traditional and managed care aspects of Medicaid and Medicare. Howard has begun to have conversations with local Medicaid MCOs about what they can do in partnership to reward and incentivize behavioral changes around how care is delivered and managed.

At the same time, Howard is striving to create a more integrated model between the operations side of the hospital and faculty side of the university’s College of Medicine. This will better position the institution to create the infrastructure needed to partner successfully with MCOs to implement value-based care models, including care delivery and treatment, and install reimbursement strategies and the appropriate technologies and analytical capabilities needed to support value-based care.

Howard is not as far along as other organizations in these initiatives. It continues to push forward with these goals while navigating a constant challenge for most organizations and especially for an academic training hospital: balancing mission while also generating a margin. Like other organizations, Howard is still figuring out how to succeed within an industry marked by changing payer dynamics while at the same time competing in today’s very competitive market.

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**The Bottom Line**

- Be courageous and provide creative leadership.
- Coach, guide and set the culture.
- Recruit physician champions.
- Build a team.
Indeed, these are multidimensional endeavors.

**Needed: Courageous and Creative Leadership**
These also are not endeavors for the meek. It will take creative leadership and courage to lead the movement to value-based care. In addition, the CEO can lead the journey to value-based care and population health in the following ways:

*Coach, guide and set the culture.* As goes the top of the organization, so goes the rest of the organization when it comes to introducing and supporting new organizational initiatives. The CEO—along with the board of trustees—must play an intimate role in modeling the organization’s vision and setting expectations for desired outcomes. When organizations move into unknown and uncomfortable areas, it is the CEO who must create space within the organization for courageous leadership.

Once an organization starts down the path to value-based care it is the CEO’s role to keep the momentum going. It is the CEO who must drive the organization forward—to coach and guide and model for staff the confidence that the organization is heading in the direction it needs to survive, thrive and serve the best interests of its community and patients. It is the CEO who has to stand up and say, “This is important for us. It’s important for our community, and we’re going to persevere through it.”

*Recruit physician champions.* These initiatives will not succeed without buy-in from physicians. This is inclusive, not exclusive work, and it requires collaborative partnerships.

Clinicians must be involved intimately in value-based care and community health strategies, including their leadership, and it is the CEO’s role to invite them.

*Build a team.* Leading today’s healthcare organizations into a new era may require different expertise and fresh perspectives. A CEO needs to build an appropriate team to lead and support the move to value-based care and population health management. This team might require nontraditional or new leadership roles, and existing leadership teams may need to be reconfigured to support this work.

Whether an organization is in an urban or rural area, value-based care is not going away. The movement toward these models is going to come in some way, shape or form because consumers, payers and the market all are demanding it to improve patient care and satisfaction and control escalating costs.

No matter where organizations are on their journeys to value-based care, CEOs must focus their teams, dedicate resources, recruit the needed expertise and seek out the unique industry partnerships that will help them succeed with these initiatives. CEOs can’t shy away from this challenge. They must grab it and go.

*James A. Diegel, FACHE, is CEO of Howard University Hospital in Washington, D.C. (jimdiegel@yahoo.com).*

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ACHE Member Update

Interim Regent Appointed
Anne-Marie A. Knight, FACHE, director, community engagement, Mayo Clinic, Jacksonville, Fla., has been appointed Interim Regent for Florida—Northern and Western.

Ethics Committee Update
ACHE’s Ethics Committee is responsible for reviewing member grievances and recommending actions to the Board of Governors on allegations regarding Code of Ethics violations. During the 2018–2019 committee year, the Ethics Committee considered six grievances concerning ACHE members. Of these, three cases were dismissed and three cases continue, pending court action.

The Ethics Committee also is responsible for conducting annual evaluations of ACHE’s Code of Ethics and Grievance Procedure and recommending updates to them. In addition, the committee reviews ACHE’s existing Ethical Policy Statements and suggests topics for new statements. This past year, the committee reviewed and revised the Ethics Self-Assessment, adding eight new statements. This issue of Healthcare Executive features ACHE’s Ethics Self-Assessment (see Page 60).

Ethics Committee members are ACHE Fellows who are appointed by the Board of Governors; they serve confidentially, with the exception of the committee chairman, whose name is made public. The Code of Ethics, Ethical Policy Statements and other ethics resources are available by visiting ache.org/EthicsToolkit.

People

Bluford Receives AHA Leadership Award
John W. Bluford III, LFACHE, founder/president, Bluford Healthcare Leadership Institute, Kansas City, Mo., received the 2019 American Hospital Association Award of Honor. The award recognizes exemplary contributions to the health and well-being of our nation through leadership on major health policy or social initiatives. The award was presented in April during AHA’s Annual Membership Meeting. Bluford has been an ACHE member since 1982.

ACHE Member Receives AHA Rural Hospital Leadership Award
Ronald “Ronnie” A. Sloan, FACHE, president, The Outer Banks Hospital, Nags Head, N.C., was awarded the AHA Rural Hospital Leadership Award. The award recognizes small or rural hospital leaders who guide their hospital and community through transformational change on the road to healthcare reform and display outstanding leadership and commitment to improving health and health coverage and making care more affordable.

Pennsylvania Health System Recognized for Community Service Excellence
Penn Medicine Lancaster (Pa.) General Health, led by ACHE Member Jan L. Bergen, president/CEO, received the 2018 Foster G. McGaw Prize for Excellence in Community Service. Sponsored by Baxter International Foundation, the American Hospital Association and the AHA’s nonprofit affiliate Health Research & Educational Trust, the prize recognizes a healthcare organization that provides innovative programs that significantly improve the health and well-being of its community.

ACHE Member-Led Organizations Receive Gallup Great Workplace Award
Five member-led organizations received the 2019 Gallup Great Workplace Award, which recognizes employee engagement. They are:

- Adena Health System, Chillicothe, Ohio, led by Jeffrey J. Graham, president/CEO

This column is made possible in part by Change Healthcare.
Official Notice for the 2019–2020 Council of Regents Elections

This official notice serves as the beginning of the election process to select new Regents to serve on the American College of Healthcare Executives’ Council of Regents, the legislative body that represents ACHE’s more than 48,000 members. Service as an elected official is a unique opportunity to exercise your leadership ability, share innovative ideas and act on behalf of fellow members.

All Fellows who wish to run for election must submit either a letter of intent to ACHE via certified mail postmarked by Aug. 23, 2019, or an electronic letter of intent to elections@ache.org. If you submit your letter of intent electronically and you haven’t received confirmation by Aug. 30, 2019, contact Caitlin E. Stine at (312) 424-9324 or cstine@ache.org.

Please note:
• New Regents will each serve a three-year term on the Council of Regents beginning at the close of the March 2020 Council of Regents meeting during ACHE’s Congress on Healthcare Leadership.
• Members are assigned to a Regent jurisdiction based on their business address.
• This official notice is the only notification for the 2019–2020 Council of Regents elections.

If you would like additional information about the responsibilities of a Regent and what to include in your letter of intent, please contact Caitlin E. Stine at (312) 424-9324 or cstine@ache.org.

ELECTIONS WILL BE HELD IN THE FOLLOWING JURISDICTIONS:
- Arizona
- California—Southern
- Canada
- District of Columbia & Northern Virginia
- Florida—Northern and Western
- Georgia
- Illinois—Metropolitan Chicago
- Maryland
- Michigan & Northwest Ohio
- Minnesota
- Missouri
- Montana
- Navy
- Nebraska & Western Iowa
- Nevada
- New Jersey—Northern
- New York—Northern and Western
- North Carolina
- North Dakota
- Ohio
- Pennsylvania
- Pennsylvania—Southeast & Southern New Jersey
- Puerto Rico
- South Carolina
- Tennessee
- Texas—Southeast
- Vermont
- Virginia—Central
- Washington
- Wyoming
Leaders in Action

They were among 40 organizations in a variety of industries that received the award.

2019 Congress Volunteer Event a Success

Sixty-five individuals participated in the annual Congress volunteer event, held March 5–6 during ACHE’s 2019 Congress on Healthcare Leadership in Chicago. This year, ACHE partnered with Together We Rise, a nonprofit organization dedicated to transforming how children experience foster care in the United States. Participants built 16 bikes for local foster children so they can experience the simple pleasure of riding their own bicycle. Additionally, volunteers constructed and decorated approximately 68 birthday boxes, packed with gifts and decorations to help foster children celebrate their birthdays.

ACHE Receives 2019 Association Forum Award

ACHE received the 2019 Welcoming Environment® Organizational Award for its demonstration of exemplary commitment in providing an inclusive and welcoming environment and culture for both its members and staff.

The award, given by the Association Forum, is based on the forum’s core value of being a Welcoming Environment®, which it defines as “the creation of a sense of belonging and connectedness that engages individuals in an authentic manner in which uniqueness is valued, respected and supported through opportunities and interaction.”

Leaders in Action

To promote the many benefits of ACHE membership, the following leaders spoke recently at these events.

David A. Olson, FACHE Immediate Past Chairman
Seattle

Sara M. Johnson, FACHE Governor
Kentucky ACHE Chapter Awards Luncheon, Kentucky Hospital Association Annual Convention (May 2019)
Lexington, Ky.

Michael A. Mayo, FACHE Governor
Orlando, Fla.

ACHE Staff Update

ACHE Announces Staff Hires and Promotions

Following are new ACHE staff members and a current employee who recently was promoted:

Andrea L. Kerr to fund coordinator, Development, Executive Office

Stacey A. Kidd to regional director, Department of Regional Services

Ife D. Lloyd to human resources coordinator, Executive Office

Andrea E. Mitchell to director, content marketing, Department of Marketing

Postgraduate Fellow, Intern Announced

James C. Glasheen has been selected as the Stuart A. Wesbury Jr. Postgraduate Fellow, and Natalia Hernández has been
selected as the ACHE Diversity Intern through the Institute for Diversity and Health Equity’s Summer Enrichment Program. ACHE and the Institute co-promote the SEP to advance the next generation of healthcare leaders. Glasheen graduated in May 2018 with a master’s degree in healthcare administration from Ferris State University, Big Rapids, Mich. Hernández is pursuing an MBA degree in healthcare administration at Cleveland State University. She expects to graduate in May 2020.

The yearlong fellowship and three-month internship offer exposure to a broad range of association management issues. The fellow and intern interact with senior-level executives and rotate through each of ACHE’s departments. Both the fellowship and internship were established in 1991 to further postgraduate education in healthcare and professional society management.

ACHE regretfully reports the deaths of the following ACHE members as reported by the Department of Member Services:

Shari Krall
Kirkland, Wash.

Martin Michael
San Francisco

Thomas J. Yarcheski
Naples, Maine

In Memoriam

It’s the motivation to go above and beyond. Move forward together and share the rich knowledge resource you’ve come to rely on. When your management team joins ACHE, there’s no telling how far you can take your organization.

Encourage your team to become part of ACHE. ache.org/Share
2018 Hospital CEO Survey on Patient Safety: Senior Staff, Patients and Families

This is the second of a series of reports from hospital CEO surveys conducted by ACHE from October 2017 through January 2018 to measure the prevalence of some key patient safety practices recommended for hospitals in *Leading a Culture of Safety: A Blueprint for Success*. The blueprint is an evidence-based, practical resource published in 2017 to assist healthcare leaders in creating a culture of safety. It was developed through a collaboration between ACHE, the IHI Lucian Leape Institute and some of the most progressive healthcare organizations and globally renowned experts in leadership, safety and culture.

Surveys were sent to 2,079 hospital CEOs who were ACHE members. Of those, 720 responded for an overall response rate of 35 percent. Some of this work was done in partnership with researchers at The Ohio State University.

Patient safety is the primary job of hospitals, and hospital performance is measured by outcomes. This study examined the prevalence of practices recommended to improve those outcomes. The table indicates the current and planned adoption rates of patient safety practices regarding the involvement of senior staff and patients and families in the hospital’s culture of safety. Survey respondents reported that patient safety was routinely discussed at senior leadership team meetings (reported by 90 percent of respondents) and employee meetings led by the CEO (85 percent). Stories about successes, “good catches” or “near misses” regarding patient safety were also often shared at these CEO-led employee meetings (78 percent). A lower proportion of respondents reported that patients and families were invited to provide feedback on hospital patient safety initiatives (67 percent).

A high proportion of CEOs in the study reported that they routinely conduct employee rounds that address patient safety issues (80 percent). Almost as many—75 percent—said they require members of their senior leadership teams to conduct employee rounds at least weekly that address patient safety issues.

ACHE wishes to thank the hospital CEOs who responded to this survey for their time, consideration and service to their profession and healthcare management research.

### Current and planned adoption rates of patient safety practices regarding involvement of the senior staff and patients and families.

<table>
<thead>
<tr>
<th></th>
<th>In place</th>
<th>Plan to have in place by end of 2018</th>
<th>No plans to have in place by end of 2018</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety is discussed at most, if not all, of your senior leadership team meetings.</td>
<td>90%</td>
<td>6%</td>
<td>4%</td>
<td>(715)</td>
</tr>
<tr>
<td>Patient safety is discussed at most, if not all, of the employee meetings you lead.</td>
<td>85%</td>
<td>8%</td>
<td>6%</td>
<td>(716)</td>
</tr>
<tr>
<td>Stories about successes, “good catches” or “near misses” regarding patient safety are shared at regular employee meetings you lead.</td>
<td>78%</td>
<td>15%</td>
<td>7%</td>
<td>(715)</td>
</tr>
<tr>
<td>As CEO, you require members of your senior leadership team to conduct employee rounds at least weekly that address patient safety issues.</td>
<td>75%</td>
<td>13%</td>
<td>12%</td>
<td>(714)</td>
</tr>
<tr>
<td>As CEO, you routinely conduct employee rounds that address patient safety issues.</td>
<td>80%</td>
<td>11%</td>
<td>9%</td>
<td>(715)</td>
</tr>
<tr>
<td>The hospital actively invites patients and their families to provide feedback on patient safety initiatives.</td>
<td>67%</td>
<td>19%</td>
<td>13%</td>
<td>(715)</td>
</tr>
</tbody>
</table>

Percentage totals may not add to 100 due to rounding.
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YOUR LEADERSHIP IS PREPARED

How do you know that your institution’s leaders can manage all aspects of healthcare delivery effectively? How do you know that your executive team members can embrace change and address the challenges that constrain quality patient care? How do you know you’re working with leaders who understand the responsibilities of a trustee?

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Learn more at ache.org/FACHE
Vi-Anne Antrum, DNP, RN, FACHE, to senior vice president/associate chief nurse executive, Cone Health, Greensboro, N.C., from CNO, Olean (N.Y.) General Hospital.

Omer F. Awan to CIO/chief digital officer, Navicent Health, Macon, Ga., from senior vice president/CIO.

Preston S. Clark to chief strategy officer, Doctors Hospital of Manteca (Calif.), from director, strategy, The Hospitals of Providence Memorial Campus, El Paso, Texas.

Andrew B. Cosentino, FACHE, to president, Saint Alphonsus Regional Medical Center, Boise, Idaho, from vice president, Swedish Neuroscience Institute, Swedish Health System, Seattle.

Heath A. Evans, FACHE, to president, Bay Medical Sacred Heart, Panama City, Fla., from CEO.

J. Gene Faile, FACHE, to retirement, from president, Wake Forest Baptist Health—Wilkes Medical Center, North Wilkesboro, N.C. We would like to thank Gene for his many years of service to the healthcare field.

Ruth O. Fisher to vice president, heart and vascular/imaging/respiratory care, Cone Health, Greensboro, N.C., from vice president, heart and vascular service line, Henry Ford Health System, Detroit.

Carol A. Friesen to CEO, Northern Region, OSF HealthCare, Peoria, Ill., from president, Health System Services, Bryan Health, Lincoln, Neb.

Omer F. Awan to CIO/chief digital officer, Navicent Health, Macon, Ga., from senior vice president/CIO.

Dennis A. Hernandez, MD, to president/CEO, AdventHealth New Smyrna Beach (Fla.), from CMO.

Gary W. Jordan, FACHE, to president/CEO, Cherokee (Iowa) Regional Medical Center, from CEO, Wright Memorial Hospital, Trenton, Mo.

Felissa Koernig, JD, FACHE, to president/COO, Guthrie Towanda (Pa.) Memorial Hospital, from associate director/COO, VA Medical Center, Charleston, S.C.

Natalie D. Lamberton, FACHE, to CEO, Talas Harbor Healthcare, Las Vegas, from CEO, New Health Pain Treatment Centers, Denver.

Arthur R. Mathisen, FACHE, to president, Memorial Hospital, North Conway, N.H., from president/CEO, Copley Hospital, Morrisville, Vt.

Kori D. Novak, PhD, to CEO, Toiyabe Indian Health Project Inc., Bishop, Calif., from CEO, Karuk Tribe Health and Human Services, Yreka, Calif.

Anthony Sudduth, FACHE, CPA, FHFMA, to CEO, Southwest Health System, Cortez, Colo., from interim CEO.

Leslie Wainwright, PhD, to chief funding/innovation officer, Parkland Center for Clinical Innovation, Dallas, from innovation advisor, health sector, RTI International, Research Triangle Park, N.C.

Amy D. Wilson, RN, to senior vice president, clinical operations, Ascension, St. Louis, from CNO, Ascension Saint Thomas Health, Nashville, Tenn.

Want to Submit? Send your “On the Move” submission to he-editor@ache.org. Due to production lead times, entries must be received by Aug. 1 to be considered for the November/December issue. See Page 2 for additional information.

This column is made possible in part by BD.
Chapter Award Winners 2019

Board of Governors Award
Sandhills Healthcare Executives Forum

Award for Chapter Excellence
ACHE—Nevada Chapter
CT Association of Healthcare Executives
Georgia Association of Healthcare Executives
Hawaii-Pacific Chapter of ACHE
Midwest Chapter of the American College of Healthcare Executives
San Diego Organization of Healthcare Leaders
Triangle Healthcare Executives’ Forum

Award of Chapter Distinction
ACHE—NJ
ACHE of Middle Tennessee
ACHE of North Texas
ACHE of Western PA
Alabama Healthcare Executives Forum
American College of Healthcare Executives of Central Florida
American College of Healthcare Executives—Wisconsin Chapter
Central Illinois Chapter of ACHE
Greater Charlotte Healthcare Executives
Mid-America Healthcare Executive’s Forum
Missouri Chapter of the American College of Healthcare Executives
South Texas Chapter of the American College of Healthcare Executives
Western Florida Chapter

Award of Chapter Merit
ACHE—MN Chapter
ACHE of Central PA
ACHE of Nebraska & Western Iowa
ACHE of Northern Ohio
American College of Healthcare Executives—Rhode Island Chapter
Arizona Healthcare Executives
Arkansas Health Executives Forum
Canadian Chapter of ACHE
Central Texas Chapter—ACHE
Colorado Association of Healthcare Executives
Great Lakes Chapter of the American College of Healthcare Executives
Healthcare Administrators of Tidewater
Health Care Executives of Southern California
Health Care Management Association of Central New York Healthcare Executive Forum, Inc.
Indiana Healthcare Executives Network
Louisiana Chapter of Healthcare Executives
Maryland Association of Health Care Executives
Mississippi Healthcare Executives
National Capital Healthcare Executives
New Mexico Healthcare Executives
Oregon Society of Healthcare Executives
Puerto Rico Chapter of the American College of Healthcare Executives, Inc.
South Carolina ACHE Chapter
South Dakota Healthcare Executive Group
South Florida Healthcare Executive Forum, Inc.
Utah Healthcare Executives
West Virginia Chapter of the American College of Healthcare Executives

Award for Sustained Performance
ACHE—MN Chapter
ACHE—Nevada Chapter
ACHE of Middle Tennessee
Alabama Healthcare Executives Forum
American College of Healthcare Executives of Central Florida
American College of Healthcare Executives—Rhode Island Chapter
American College of Healthcare Executives—Wisconsin Chapter
Arkansas Health Executives Forum
Central Illinois Chapter of ACHE
CT Association of Healthcare Executives
Georgia Association of Healthcare Executives
Greater Charlotte Healthcare Executives
Hawaii-Pacific Chapter of ACHE
Indiana Healthcare Executives Network
Mid-America Healthcare Executive’s Forum
Midwest Chapter of the American College of Healthcare Executives
Oregon Society of Healthcare Executives
San Diego Organization of Healthcare Leaders
South Texas Chapter of the American College of Healthcare Executives
Utah Healthcare Executives
The American College of Healthcare Executives congratulates members who recently received awards recognizing their contribution to healthcare management.

**LCDR James Adwell, FACHE**, director, public health, Naval Health Clinic Charleston, Goose Creek, S.C., received the Early Careerist Healthcare Executive Award from the Regent for Navy.

**Nancy H. Agee, FACHE**, president/CEO, Carilion Clinic, Roanoke, Va., received the Distinguished Service Award from the Regent for Virginia—Central.

**Joyce G. Brown, FACHE**, chief, voluntary service, South Texas Veterans Health Care System, San Antonio, received the Senior Level Healthcare Executive Award from the Regent for Veterans Affairs.

**MAJ Michael F. Brown III, FACHE**, nurse methods analyst, U.S. Army, Richmond Hill, Ga., received the Early Careerist Healthcare Executive Award from the Regent for Army.

**COL Thomas S. Bundt, PhD, FACHE**, commander/director/CEO, Madigan Army Medical Center, Dupont, Wash., received the Career Achievement Award from the Regent for Army.

**Sherae D. Campbell**, program manager, Cleveland VA Medical Center, received the Individual Accomplishments in Diversity Early Careerist Award from the Regent-at-Large for District 6.

**Barry R. Cesafsky, FACHE**, president/CEO, CES Partners Ltd., Chicago, received the Significant Sig Award from the Sigma Chi Fraternity.

**LTC Chani Cordero, FACHE**, CIO, Defense Health Agency, San Antonio, received the Individual Accomplishments in Diversity Senior Level Award from the Regent-at-Large for District 6. Cordero also received the Senior Level Healthcare Executive Award from the Regent for Army.

**Mark A. Dame, FACHE**, program director/professor, BSHM Program, Texas Tech University Health Sciences Center, Lubbock, Texas, received the Outstanding Teacher of the Year Award from the Student Government Association.


**CAPT Robert S. Fry, PhD, FACHE**, received the Lifetime Service Award from the Regent for Navy.

**Lt Col Charles S. Hughes, FACHE**, commander, 99th Medical Support Squadron, U.S. Air Force, Nellis Air Force Base, Nev., received the Senior Level Healthcare Executive Award from the Regent for Air Force.

**William D. Jacobsen, FACHE(R)**, Illumination LLC, Roanoke, Va., received the Senior Level Healthcare Executive Award from the Regent for Virginia—Central.

**Ashley R. McClellan, FACHE**, president/CEO, The Woman’s Hospital of Texas, Houston, received the Healthcare Executive Award from the Regent for Texas—Southeast.

**Alice M. Meyer, FACHE**, senior consultant, Population Health Solutions, Bon Secours Mercy Health, Glen Allen, Va., received the Healthcare Executive Award from the Regent for Virginia—Central.

**CAPT Devin J. Morrison, FACHE**, director, administration, Naval Medical Center Portsmouth (Va.), received the Senior Level Healthcare Executive Award from the Regent for Navy. Morrison also received the Outstanding Service Award.
Award from the Regent for Virginia—Central.

**Kenneth J. Mortimer, FACHE**, associate medical center director, Hershel “Woody” Williams VA Medical Center, Huntington, W.Va., received the Early Careerist Healthcare Executive Award from the Regent for Veterans Affairs.

**Roberta L. Schwartz, PhD, FACHE**, executive vice president/chief innovation officer, Methodist Hospital, Houston, received the Healthcare Executive Award from the Regent for Texas—Southeast.

**Meredith B. Strand**, director, cancer program, Sentara Norfolk (Va.) General Hospital, received the Healthcare Executive Award from the Regent for Virginia—Central.

**Patricia A. Winston, RN, FACHE**, interim senior vice president/managing director, SUNY University Hospital of Brooklyn (N.Y.), received one of the 2019 Most Influential Black Women in Business Awards from *The Network Journal*.

**Want to Submit?** Send your “Member Accolades” submission to [he-editor@ache.org](mailto:he-editor@ache.org). Due to production lead times, entries must be received by Aug. 1 to be considered for the November/December issue. See Page 2 for additional information.
Lifelong learning is a core value of ACHE, and when you participate in a chapter event you ensure that value is met. Thank you. And, no matter where you live, whether it’s in metropolitan New York or Chicago, or in rural Kansas or Montana, there’s an excellent opportunity for learning at your chapter.

Chapters have become increasingly instrumental in providing educational opportunities to their members. At the local level you can access convenient, close-to-home education, networking opportunities and career development services, and gain ACHE Face-to-Face Education and Qualified Education credits. Face-to-Face programs foster immediate, in-person dialogue and idea exchange among program attendees, while Qualified Education provides a variety of activity modalities and sources of educational materials. Both forms of programming are essential for a well-rounded learning plan. For ACHE, they also meet the requirements for Members to earn board certification in healthcare management as an ACHE Fellow or to recertify their credential.

Opportunities for Education Credit
Every member of ACHE is automatically a member of one of 78 chapters across the United States, Canada and elsewhere, where learning opportunities abound. For example, each chapter has at its disposal a 90-minute panel discussion format that allows members the chance to earn a maximum of 12 unique ACHE Face-to-Face Education credit hours per year. Panel discussions include a moderator and two or three panelists from a variety of backgrounds to ensure the audience hears unique insights and different points of view.

Panel discussion topics cover a range of ongoing issues and healthcare trends, including:

- Fostering Inclusion of Patients and Employees with Disabilities
- Effectively Managing Behavioral Health/Psychiatric Patient Throughput in the Emergency Department
- Sustainable Strategies to Support Resiliency and Professional Well-Being for Healthcare Professionals
- Successfully Leading Change in Healthcare Organizations

Members Learn About Patient Safety at the Local Level
Members of ACHE—NJ, which encompasses most of New Jersey, recently had the opportunity to attend an all-day program on the topic of patient safety, an important initiative for ACHE and members. The topic also is an important one for Alex Puma, president, ACHE—NJ, who is on a high-reliability journey in his daily work.
“Patient safety is a priority for ACHE, and it made sense for the chapter to plan and hold this type of event,” says Puma. “This is an important topic that everyone in the community can get behind.”

Chapters have become increasingly instrumental in providing educational opportunities to their members.

Puma and Mary A. Ditri, a member-at-large of ACHE—NJ, coordinated the chapter’s first all-day summit, which included 16 panelists from numerous area healthcare systems. Approximately 80 professionals attended, with ACHE members earning 6 ACHE Face-to-Face Education credits.

“It’s not often we can bring competing healthcare organizations together to talk about a common topic, but we all know how important patient safety is,” says Puma. “These opportunities are made possible by the local chapter, which is the glue for these members.”

Get Involved
Volunteering on your chapter’s education committee is an effective way to engage with your chapter’s leadership and support high-quality programs and services. If your chapter does not have an education committee, consider working with the chapter board to organize an event that could benefit members in your area and encourage involvement.

To find your ACHE chapter, search the online Chapter Directory at ache.org by selecting your state/country in the drop-down menu. Then, contact the chapter officials listed for information on how you can get involved. To discuss your ideas for chapters, contact the Chapters Committee’s ACHE staff liaison, Jennifer L. Connelly, FACHE, CAE, interim vice president, Department of Regional Services, at (312) 424-9320 or jconnelly@ache.org.

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Special Offer

Buy one Self-Study course and receive a second course at a 50% discount (phone orders only)

Earn ACHE Qualified Education Credit—Anytime, Anywhere

By completing Self-Study courses, you can earn ACHE Qualified Education credits toward your Fellow recertification. Courses cover a variety of topics, including finance, management, leadership, human resources and strategy.

To order, visit ache.org/SelfStudy or call the ACHE/HAP Order Fulfillment Center at (301) 362-6905.
September 2019

**Baltimore Cluster**

16–17  Closing the Gap in Physician Engagement, Alignment and Integration in a Value-Based Environment

Leadership and Accountability in Project Management and Programs

Physician and Executive Partnerships: Hard Facts, Soft Skills

Thriving During Times of Uncertainty—**NEW**

17  The Basics of Grassroots Advocacy

18–19  Agility and Resilience in Healthcare Leadership: Key Behaviors for Leading Change—**NEW**

The Courage to Lead: Critical Skills for Healthcare Leaders

Critical Financial Skills for Hospital Success

Hospitals and Health Systems of the Future: Transforming to Thrive

Improving the Patient Experience to Build Customer Loyalty

[ache.org/Baltimore](http://ache.org/Baltimore)

**Board of Governors Examination Review Course**

**Atlanta**

This 2½-day course reviews the BOG Exam’s knowledge areas, provides general test-taking strategies and improves your understanding of the Exam’s content, structure and scoring.

[ache.org/BOGReview](http://ache.org/BOGReview)

October 2019

**CEO Circle Forum 2019:**

**Monetizing Quality in a Pay-for-Value World**

**Coral Gables, Fla.**

Expert faculty guide you in converting quality metrics into meaningful financial outcomes through case studies and hands-on application. This session also addresses business plan development for proposed payer and provider contracts to maximize value and align organization interests with key stakeholders’ interests.

This seminar is designated exclusively for CEOs of healthcare provider organizations.

[ache.org/CEOForum](http://ache.org/CEOForum)

Completion of course(s) earns ACHE Face-to-Face Education credit, which counts toward Fellow advancement and recertification. Visit [ache.org/FACHE](http://ache.org/FACHE) for more information on advancement and recertification requirements.
Las Vegas Cluster
14–15  Agility and Resilience in Healthcare Leadership: Key Behaviors for Leading Change—NEW!
       Leading for Success: Creating a Committed Workforce
       Proven Strategies and Leadership Methods for Effectively Leading Change in Today’s Environment
       Toxic Behaviors in Healthcare: How Everyday Civility Increases Patient Safety and Team Performance
16–17  Advanced Strategic Planning to Transform Your Organization
       Leading for Change: Creating a Humanistic Approach for Patient, Family and Staff Engagement
       Leading in a Changing Environment: Focus on Population Health
       Managing Healthcare Facility Design and Construction Programs

ache.org/LasVegas

New Orleans Cluster
21–22  Behavior Smarts: Increasing Healthcare Leadership Performance
       Critical Success Factors in Moving Toward Value-Based Care
       Culture: The Force Behind Strategy
       Leading Strategic Change
22    Never Be Boring: Present Like a Pro—NEW
23–24  Achieving Speed, Spread, Scalability and Sustainability for Health Systems
       Creating Successful Physician Integration and Engagement Strategies for Long-Term Success
       Leading for Success: Creating a Committed Workforce
       Possibilities, Probabilities and Creative Solutions: Breakthrough Thinking for Complex Environments

ache.org/NewOrleans

Leadership Development Program
Chicago
Skill assessments, personalized feedback, individual coaching sessions and lectured group exercises enhance your leadership capacity to drive organizational success. You will gain valuable and enlightening information about your leadership, decision-making and communication skills, and the impact you have on others.

ache.org/LDP
Purpose of the Ethics Self-Assessment

Members of the American College of Healthcare Executives agree, as a condition of membership, to abide by ACHE’s Code of Ethics. The Code provides an overall standard of conduct and includes specific standards of ethical behavior to guide healthcare executives in their professional relationships.

Based on the Code of Ethics, the Ethics Self-Assessment is intended for your personal use to assist you in thinking about your ethics-related leadership and actions. It should not be returned to ACHE, nor should it be used as a tool for evaluating the ethical behavior of others.

The Ethics Self-Assessment can help you identify those areas in which you are on strong ethical ground, areas in which you may wish to examine the basis for your responses and opportunities for further reflection. The Ethics Self-Assessment does not have a scoring mechanism, as we do not believe that ethical behavior can or should be quantified.

How to Use This Self-Assessment

We hope you find this self-assessment thought provoking and useful as a part of your reflection on applying the ACHE Code of Ethics to your everyday activities. You are to be commended for taking time out of your busy schedule to complete it.

Once you have finished the self-assessment, it is suggested that you review your responses, noting which questions you answered “usually,” “occasionally” and “almost never.” You may find that in some cases an answer of “usually” is satisfactory, but in other cases, such as when answering a question about protecting staff’s well-being, an answer of “usually” may raise an ethical red flag.

We are confident that you will uncover few red flags where your responses are not compatible with the ACHE Code of Ethics. For those you may discover, you should use this as an opportunity to enhance your ethical practice and leadership by developing a specific action plan. For example, you may have noted in the self-assessment that you have not used your organization’s ethics mechanism to assist you in addressing challenging ethical conflicts. As a result of this insight, you might meet with the chair of the ethics committee to better understand the committee’s functions, including case consultation activities and how you might access this resource when future ethical conflicts arise.

We also want you to consider ACHE as a resource when you and your management team are confronted with difficult ethical dilemmas. Access the Ethics Toolkit, a group of practical resources that will help you understand how to integrate ethics into your organization, at ache.org/EthicsToolkit. In addition, you can refer to our regular “Healthcare Management Ethics” column in Healthcare Executive magazine.
Please check one answer for each of the following questions.

<table>
<thead>
<tr>
<th>I. LEADERSHIP</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>I take courageous, consistent and appropriate management actions to</td>
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<td>overcome barriers to achieving my organization’s mission.</td>
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<td>I place community/patient benefit over my personal gain.</td>
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<td>I strive to be a role model for ethical behavior.</td>
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<td>I work to ensure that decisions about access to care are based primarily</td>
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<td>on medical necessity, not only on the ability to pay.</td>
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<td>My statements and actions are consistent with professional ethical</td>
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<tr>
<td>standards, including the ACHE Code of Ethics.</td>
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<tr>
<td>My statements and actions are honest, even when circumstances would allow</td>
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<td>me to confuse the issues.</td>
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<tr>
<td>I advocate ethical decision making by the board, management team and</td>
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<td>medical staff.</td>
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<tr>
<td>I use an ethical approach to conflict resolution.</td>
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<tr>
<td>I initiate and encourage discussion of the ethical aspects of management/</td>
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<td>financial issues.</td>
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<td>I initiate and promote discussion of controversial issues affecting</td>
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<td>community/patient health (e.g., domestic and community violence and</td>
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<td>decisions near the end of life).</td>
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<td>I promptly and candidly explain to internal and external stakeholders</td>
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<td>negative economic trends and encourage appropriate action.</td>
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<td>I use my authority solely to fulfill my responsibilities and not for self-</td>
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<td>interest or to further the interests of family, friends or associates.</td>
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<tr>
<td>When an ethical conflict confronts my organization or me, I am successful</td>
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<td>in finding an effective resolution process and ensuring it is followed.</td>
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<tr>
<td>I demonstrate respect for my colleagues, superiors and staff.</td>
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<tr>
<td>I demonstrate my organization’s vision, mission and value statements in my</td>
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<td>actions.</td>
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<td>I make timely decisions rather than delaying them to avoid difficult or</td>
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<td>politically risky choices.</td>
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<td>I seek the advice of the ethics committee when making ethically challenging decisions.</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td>Not Applicable</td>
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<td>My personal expense reports are accurate and are only billed to a single organization.</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
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<td>Not Applicable</td>
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<tr>
<td>I openly support establishing and monitoring internal mechanisms (e.g., an ethics committee or program) to support ethical decision making.</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td>Not Applicable</td>
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<tr>
<td>I thoughtfully consider decisions when making a promise on behalf of the organization to a person or a group of people.</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td>Not Applicable</td>
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<td></td>
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<tr>
<td>I take responsibility for understanding workplace violence and take steps to eliminate it.</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
<td>Always</td>
<td>Not Applicable</td>
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</table>

### II. RELATIONSHIPS

#### Community
I promote community health status improvement as a guiding goal of my organization and as a cornerstone of my efforts on behalf of my organization.  
 | Almost Never | Occasionally | Usually | Always | Not Applicable |
|---|---|---|---|---|---|
| | | | | | |
| I personally devote time to developing solutions to community health problems. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I participate in and encourage my management team to devote personal time to community service. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I engage in collaborative efforts with healthcare organizations, businesses, elected officials and others to improve the community’s well-being. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I seek to identify, understand and eliminate health disparities in my community. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I seek to understand and identify the social determinants of health in my community. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |

#### Patients and Their Families
I use a patient- and family-centered approach to patient care.  
<p>| Almost Never | Occasionally | Usually | Always | Not Applicable |
|---|---|---|---|---|---|
| | | | | | |
| I am a patient advocate on both clinical and financial matters. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I ensure equitable treatment of patients, regardless of their socioeconomic status, ethnicity or payer category. | Almost Never | Occasionally | Usually | Always | Not Applicable |
| | | | | | |
| I respect the practices and customs of a diverse patient population while maintaining the organization’s mission. | Almost Never | Occasionally | Usually | Always | Not Applicable |</p>
<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<tr>
<td>I demonstrate through organizational policies and personal actions that overtreatment and undertreatment of patients is unacceptable.</td>
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<td>I protect patients’ rights to autonomy through access to full, accurate information about their illnesses, treatment options, and related costs and benefits.</td>
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<td>I promote a patient’s right to privacy, including medical record confidentiality, and do not tolerate breaches of this confidentiality.</td>
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<td>I am committed to eliminating harm in the workplace.</td>
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<td>I am committed to helping address affordability challenges in healthcare.</td>
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<td><strong>Board</strong></td>
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<td>I have a routine system in place for board members to make full disclosure and reveal potential conflicts of interest.</td>
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<td>I ensure that reports to the board, my own or others’, appropriately convey risks of decisions or proposed projects.</td>
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<td>I work to keep the board focused on ethical issues of importance to the organization, community and other stakeholders.</td>
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<td>I keep the board appropriately informed of patient safety and quality indicators.</td>
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<td>I promote board discussion of resource allocation issues, particularly those where organizational and community interests may appear to be incompatible.</td>
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<td>I keep the board appropriately informed about issues of alleged financial malfeasance, clinical malpractice and potentially litigious situations involving employees.</td>
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<td><strong>Colleagues and Staff</strong></td>
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<td>I foster discussions about ethical concerns when they arise.</td>
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<td>I maintain confidences entrusted to me.</td>
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<td>I demonstrate through personal actions and organizational policies zero tolerance for any form of staff harassment.</td>
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<tr>
<td>Statement</td>
<td>Almost Never</td>
<td>Occasionally</td>
<td>Usually</td>
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<td>Not Applicable</td>
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<td>--------------------------------------------------------------------------</td>
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<td>I encourage discussions about and advocate for the implementation of the organization's code of ethics and value statements.</td>
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<td>I fulfill the promises I make.</td>
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<td>I am respectful of views different from mine.</td>
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<tr>
<td>I am respectful of individuals who differ from me in ethnicity, gender, education or job position.</td>
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<td>I convey negative news promptly and openly, not allowing employees or others to be misled.</td>
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<tr>
<td>I expect and hold staff accountable for adherence to our organization's ethical standards (e.g., through performance reviews).</td>
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<td>I demonstrate that incompetent supervision is not tolerated and make timely decisions regarding marginally performing managers.</td>
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<tr>
<td>I ensure adherence to ethics-related policies and practices affecting patients and staff.</td>
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<td>I am sensitive to employees who have ethical concerns and facilitate resolution of these concerns.</td>
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<tr>
<td>I encourage the use of organizational mechanisms (e.g., an ethics committee or program) and other ethics resources to address ethical issues.</td>
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<td>I act quickly and decisively when employees are not treated fairly in their relationships with other employees.</td>
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<td>I assign staff only to official duties and do not ask them to assist me with work on behalf of my family, friends or associates.</td>
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<tr>
<td>I hold all staff and clinical/business partners accountable for compliance with professional standards, including ethical behavior.</td>
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<td>I am sensitive to the stress of the healthcare workforce (including physicians and other clinicians), and take steps to address personal wellness and professional fulfillment, such as incorporating these issues in employee and physician satisfaction/engagement surveys.</td>
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<td>I take steps to understand my workforce as it relates to safety, stress and burnout and consider the impact of those who are in positions of authority (including executives and physicians).</td>
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**Clinicians**

<table>
<thead>
<tr>
<th>When problems arise with clinical care, I ensure that the problems receive prompt attention and resolution by the responsible parties.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<tr>
<th>I insist that my organization’s clinical practice guidelines are consistent with our vision, mission and value statements and ethical standards of practice.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<tr>
<th>When practice variations in care suggest quality of care is at stake, I encourage timely actions that serve patients’ interests.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
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<th>Not Applicable</th>
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<tr>
<th>I insist that participating clinicians and staff live up to the terms of managed care contracts.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
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<th>Not Applicable</th>
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<tr>
<th>I encourage clinicians to access ethics resources when ethical conflicts occur.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
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<th>Not Applicable</th>
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<th>I encourage resource allocation that is equitable, is based on clinical needs and appropriately balances patient needs and organizational/clinical resources.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
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<th>Not Applicable</th>
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<th>I expeditiously and forthrightly deal with impaired clinicians and take necessary action when I believe a clinician is not competent to perform his/her clinical duties.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
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<th>Not Applicable</th>
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<tr>
<th>I expect and hold clinicians accountable for adhering to their professional and the organization’s ethical practices.</th>
<th>Almost Never</th>
<th>Occasionally</th>
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<th>Always</th>
<th>Not Applicable</th>
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**Buyers, Payers and Suppliers**

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<thead>
<tr>
<th>I negotiate and expect my management team to negotiate in good faith.</th>
<th>Almost Never</th>
<th>Occasionally</th>
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<th>I am mindful of the importance of avoiding even the appearance of wrongdoing, conflict of interest or interference with free competition.</th>
<th>Almost Never</th>
<th>Occasionally</th>
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<th>Not Applicable</th>
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<tr>
<th>I personally disclose and expect board members, staff members and clinicians to disclose any possible conflicts of interest before pursuing or entering into relationships with potential business partners.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<th>I promote familiarity and compliance with organizational policies governing relationships with buyers, payers and suppliers.</th>
<th>Almost Never</th>
<th>Occasionally</th>
<th>Usually</th>
<th>Always</th>
<th>Not Applicable</th>
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<th>I set an example for others in my organization by not accepting personal gifts from suppliers.</th>
<th>Almost Never</th>
<th>Occasionally</th>
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<th>Not Applicable</th>
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Statement of the Issue
Board evaluation of the hospital or health system CEO is an important way to ensure strategic alignment and monitor organizational and individual performance. Its intent is to align the CEO’s understanding of the board’s performance expectations and receive feedback on the board’s assessment of progress and improvement toward attaining the mission and vision of the organization, as well as realigning the strategy, as necessary. In an environment characterized by unprecedented challenges, risks and uncertainty, CEOs are faced with new and more complex responsibilities. Concurrently, public and regulatory expectations demand that boards demonstrate higher levels of accountability for core responsibilities such as strategic plan development and oversight. The evaluation of leadership performance is a critical governance and business process that results in shared vision, feedback, and a consistent review and learning process. As a result, the board’s evaluation of the CEO requires a well-designed, ongoing system for measuring leadership effectiveness and the attainment of established goals and objectives.

Policy Position
The American College of Healthcare Executives believes the board of a hospital or health system should regularly monitor organizational/individual performance, providing feedback as needed, and at a minimum annually provide a formal evaluation of the CEO’s performance, in accordance with the following principles:

- Periodic review of organizational/individual performance instills a transparent process around performance expectations so that neither party is surprised during the formal annual evaluation process.
- Continuous feedback and learning is critical to effective board and CEO alignment related to strategy, performance, results and the need for continuous improvement.
- A formal annual evaluation should include an assessment of the CEO’s performance on core leadership responsibilities consistent with the CEO’s job description and annual performance goals.
- The board should establish a balanced scorecard of well-defined, measurable objectives to be used in evaluating CEO performance in a continuous cycle of performance evaluation.
- The continuous evaluation cycle should clarify and translate the organization’s vision and strategy; effectively communicate and educate the parties on goals and performance measures; set achievable targets while aligning strategic initiatives, resources and milestones; and result in a shared vision supported by regular feedback that provides review and learning.
- Certain leadership traits, such as judgment, communication and diplomacy, may require board assessment. To the greatest extent possible, the board should evaluate the CEO’s performance based on relevant, multifaceted scorecard metrics relating to performance against the strategic plan, including but not limited to community, organizational and/or individual professional objectives:
Evaluating the Performance of the Hospital or Health System CEO (cont.)

- Providing the CEO with consistent feedback should be a continuous process involving the board chair at a minimum and/or other appropriate board members who may confer with the CEO regularly.

- The board should participate by providing annual feedback through a formal annual process that collects and collates individual board member assessments of CEO performance, which are considered through a documented process with discussion.

- The evaluation process should culminate in a formal, annual performance review.

- A continuous evaluation process facilitates timely, meaningful feedback on aspects of board governance and strategic planning, and establishes expectations that assist in avoiding future misunderstandings.

- Enhancing the working relationship and information-sharing between the CEO and the board is critical to success, and should not be a one-directional process.

- The board or a subcommittee of the board should align pay and performance as part of the formal annual performance review process.

- Adjustments in compensation should be based on an independent, fair market value assessment, and assess a balanced scorecard of goals and objectives established as part of the annual and ongoing planning process.

- As part of the CEO evaluation process, the CEO should complete a self-evaluation; a board self-evaluation process should be considered also. Self-evaluations of the full board and individual members provide context to the CEO performance evaluation process by assessing the extent to which board members perceive the board provided clear expectations, effective guidance and feedback to the CEO throughout the year.

An important responsibility of a hospital or health system board is the development and implementation of a documented, well-designed, ongoing process for providing feedback to the CEO and measuring progress and achievement. These principles guide a process that increases communication between the board and the CEO, which can improve the probability of organizational success.

Approved by the Board of Governors of the American College of Healthcare Executives on Nov. 12, 2018.

Reference

Performance Management

Transform Performance Management Into Performance Development

Traditional performance management systems consume an enormous amount of organizational time and money. Yet, the impact of these review programs has been less than stellar. According to Gallup analytics, only 14% of employees strongly agree that performance reviews inspire them to improve. The research also suggests that performance management must transform into performance development—an approach that focuses on growing leaders, not just keeping employees accountable.

Leaders seeking to develop their managers into successful leaders must focus on three vital actions:

1. **Establish expectations.** To be effective, leaders need to become skilled in setting clear, collaborative and aligned expectations, and employees must be involved in the process of doing so. When a team is included in setting their goals, they are more likely to be engaged and believe the goals are fair and are thus more motivated to achieve them. During a review, share top priorities in need of accomplishment. Encourage direct reports to share their own objectives as well—what they will accomplish, when it will be done and how success will be measured.

2. **Coach continuously.** Provide frequent, focused and future-oriented performance conversations. Minimally, provide meaningful feedback weekly and substantial developmental coaching monthly. Mutually agreed-on goals form the basis for these ongoing coaching conversations. These conversations provide an opportunity to adjust goals as the business changes, rather than waiting for formal progress reviews when it is often too late.

   During regular conversations, address negative issues, and recognize and praise success. Not only do frequent, honest conversations keep teams accountable, they also improve perceptions of fairness.

   A coach must understand the strengths and weaknesses of the team and position each player to reach the highest potential for the greater good.

3. **Create accountability.** To be meaningful, accountability needs to be achievement-oriented, fair, accurate and developmental. Achievement-oriented reviews reframe conversations around future performance, continuous improvement and recognition. Similarly, developmental conversations focus on identifying natural talents and growing them into strengths.

   Developing others to become the best versions of themselves gives work meaning that ultimately translates into higher performance and successful future leadership.

*Source: Adapted from an article by Gallup Inc. Visit www.gallup.com/workplace/232964/expensive-mistake-leaders.aspx.*
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Researchers at America’s Biopharmaceutical Companies are closer than ever to getting an upper hand on lupus. Now, with 39 new treatments in development, we’re hoping to see the end of lupus in our lifetime.

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