

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

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Cover Story

- 8** **Top 5 Approaches to Physician Satisfaction: Advice for Times of Crisis and for Every Day**



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Even during an unprecedented event like the COVID-19 pandemic, healthcare executives may wonder how to best preserve their valued relationships with physicians as they cope with the ramifications of the global emergency.

Feature

- 18** **Behavioral Healthcare Now and Post COVID-19: Integrating Telemental Health Services**



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The pandemic thrust telemental health into the spotlight. Now that many organizations have made the transition, early signs are that this option will last.

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Recent Healthcare Executive Podcasts



You can find the following interviews at [HealthcareExecutive.org/Podcast](https://www.healthcareexecutive.org/podcast) or search for “Healthcare Executive” in Apple Podcasts or iTunes:

Warner Thomas, FACHE, CEO, Ochsner Health, discusses the impact of the COVID-19 pandemic on operations, staff, patients and the community.

Banner Health’s senior director of digital marketing, Chris Pace, talks about the “digital front door” and how it drives growth, loyalty and better care.

Georges C. Benjamin, MD, executive director of the American Public Health Association, explains how healthcare leaders can help patients navigate the pandemic and the skills executives need to lead through a crisis.

Fresh, Exclusive Content

Read the following recent articles only at [HealthcareExecutive.org/WebExtras](https://www.healthcareexecutive.org/webextras):

“Helping Physicians During the COVID-19 Pandemic.”

Healthcare executives can do a lot to support their physicians on the front line of the COVID-19 crisis. Experts recommend several strategies for helping physicians manage the physical, emotional and financial toll of battling the virus.

“**Tiered Staffing Strategy for Pandemics.**” The need to staff new inpatient and ICU beds has encouraged the creative use of the existing workforce supplemented by clinicians working in new roles, students stepping in and retirees returning to work.

COVID-19 Member News

As this unprecedented event continues to impact our communities, ACHE will regularly share news about our members on the front lines. These news stories are intended to highlight the amazing work our leaders are doing as they confront the novel coronavirus and the disease caused by it, COVID-19.

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Frank W. Austin

Clinical Integration in Challenging Times

The theme of the two features in this issue is clinical integration. The cover story explores a key ingredient to success: physician satisfaction. The second feature looks at how the care of behavioral health patients is integrated with telemental health services. Both topics are explored in the wake of COVID-19.

In our cover story “Top 5 Approaches to Physician Satisfaction: Advice for Times of Crisis and for Every Day” (Page 8), we discuss how despite COVID-19 disrupting most if not all organizations’ operations, it’s imperative that healthcare executives stay focused on physician satisfaction, engagement and well-being. “Caring about professional well-being is the way that organizations are going to best achieve the other outcomes that they are working toward,” says Christine A. Sinsky, MD, a general internist and vice president of professional satisfaction at the American Medical Association.

In the feature article “Behavioral Healthcare Now and Post COVID-19: Integrating Telemental Health Services” (Page 18), we examine how hospitals and health systems moved quickly to a virtual model to continue psychotherapy and psychiatric management for patients. Now that many organizations have made the transition, early signs are that this option will last.

In addition, you’ll find the Ethics Self-Assessment (Page 58), 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 revises the Ethics Self-Assessment. There were no changes made this year.

I hope you enjoy this issue of *Healthcare Executive*. Please share your feedback with me at he-editor@ache.org. ▲

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Deborah J. Bowen,
FACHE, CAE

Creating a Healthier, More Equitable Future

Building a more just “new normal” after COVID-19.

For many weeks, the healthcare community has been immersed in taking care of patients and families and getting through the pandemic. While we are slowly emerging and the rise of COVID-19 incidences lessens for many, we have a more enduring toll to face in racial injustice.

As a white leader, I don’t profess to understand the depth of pain others have faced, but I do know that leaders can play powerful and influential roles in driving change. I also know that as a professional community, healthcare leaders are adept at achieving what we set our hearts and minds to achieve. So I wonder, as we consider what we have learned during COVID-19, how we might devise a “new normal” that helps ensure equity for all in our plans and actions.

To help move forward, we must solve for what we can influence. Leaders across the country will benefit from lessons learned from the pandemic, but we must also take hold of the fundamental values that differentiate healthcare organizations. How can we best integrate these two priorities to provide meaningful change—to serve all patients while taking advantage of what we now know in managing the pandemic? What lessons have we learned—about our institutions, our workforce and our communities—that can propel us to a new future?

Enhanced Planning

Preparedness is a staple in healthcare management, but the scope of this pandemic exceeded the imagination of even the most stringent plan or best simulation. The response was swift

and massive. For many organizations, this meant creating new intensive care units in a matter of days. It meant halting elective surgeries to expand capacity. It meant examining our supply chains to ensure there were enough protective equipment, ventilators and other vital supplies. It meant activating command centers to help ensure communication and transparency both inside and outside the organization.

We know now that we can rise to these challenges, as hard as it is. We can leverage systemness to increase capacity for critical patients. We can create advanced field hospitals and deploy the might of the U.S. military to reinforce our ranks. We can leverage partnerships and navigate supplier networks to creatively source critical materials.

Emergency preparedness plans must include mitigation of harm against vulnerable communities. Many experts are predicting a second wave as the country re-opens, or a combined COVID-19/influenza season that may again take a heavy toll on those marginalized. While we will not be able to remedy generations of disparities in a matter of months, we can consider what education, outreach and resources can be deployed to reduce infection and death rates. As “leaders who care” we have both moral and business imperatives to increase access to information, testing and treatment. Performing analyses now of how and why different populations were most impacted—minority communities, low-income neighborhoods, individuals with disabilities and pre-existing conditions, homeless or housing vulnerable—will help us develop appropriate pre-emptive actions.

Diversity and Inclusion Resources

For more data and resources on addressing inequities in health outcomes and the healthcare management field, please visit:

ACHE Asian Healthcare Leaders Forum: [ache.org/AHLF](https://www.ache.org/AHLF)

ACHE LGBTQ Forum: [ache.org/LGBTQ](https://www.ache.org/LGBTQ)

ACHE research studies: [ache.org/Workplace](https://www.ache.org/Workplace)

Executive Diversity Career Navigator: [edcnavigator.org](https://www.edcnavigator.org)

Institute for Diversity and Health Equity: [ifdhe.aha.org](https://www.ifdhe.aha.org)

National Association of Health Services Executives: [nahse.org](https://www.nahse.org)

National Association of Latino Healthcare Executives: [nalhe.org](https://www.nalhe.org)

Learning and research from across the field can and must be used to create, rehearse and codify stronger plans. As we reevaluate, we can take stock of our successes and opportunities for improvement. And we can celebrate the breadth of contributors—C-suite executives, front-line care providers, first responders, community leaders, public health officials, patients and families, and so many others—who helped expand our resources and lift our spirits.

Accelerated Innovation

Many leaders have emphasized the speed at which the situation on the ground developed and intensified. As a result, organizations accelerated decision-making, adapting to a new cadence to ensure the best care possible. Implementation that might previously have taken weeks or months has been happening in days or even hours. Assessments and adjustments are also happening on a more rapid and continual basis. We've also seen ingenuity play out through community partnerships, from universities to hotels to manufacturers, to increase access to vital resources. As we deepen and formalize these relationships, we can gain the benefit of our collective actions.

Agility and innovation have created a momentum, while rapid evolution has occurred in parallel. For instance, the massive uptake of telemedicine and virtual visits has opened the door to a range of possibilities, including advancements in triaging people showing symptoms of COVID-19 or monitoring patients with chronic conditions. In many places, nurses and doctors are leveraging technology to connect hospitalized patients with their loved ones.

As we look to hardwire telemedicine practices, we need to be mindful that ensuring access for all may also require alternate approaches. With many people balancing the struggle to care for their loved ones while facing disruptions in income, some may have limited access to technology. We must practice intentional inclusion to ensure that the accelerated pace doesn't leave already-underserved populations even farther behind.

Workforce Support

The physical health of our workforce is paramount to our ability to persist in tackling this pandemic. Healthcare leaders have developed new ways to help reduce exposure and keep care providers from contracting or transferring the virus.

Amid this, we've discovered a new depth to our talent pools by creatively realigning talent with need. Staff reassignments are occurring across the board, from medical office nurses and PAs performing drive-through testing, to administrators and practice managers undertaking ED triage, to social workers running a daycare for children of essential employees.

In addition, we've recognized how critical it is to preserve psychological health and prevent burnout. Organizations activated a host of options during the height of the pandemic to create space and time for staff to decompress and recharge. We've offered mental health training and digital tools to help reduce stress, and provided mental health check-ins.

Though the number of COVID-19 cases may vary in different areas, we should hold on to the realization that mental health and burnout do not

start and stop at the hospital walls. COVID-19 has shined a harsh light on long-standing health disparities that have persisted for too long. Many of our employees return to families and communities that are suffering from the acute situation of the pandemic but also from legacies of disinvestment and injustice. The "full picture" of health is as equally important to consider for our employees as it is for the patients in our beds and exam rooms.

This is particularly important, as we know that the financial fallout of COVID-19 may result in difficult and painful decisions with regard to our workforce. Moving forward, we must think carefully about how to cultivate and maintain holistic health for employees *as part* of the broader communities we serve.

Thank You

Throughout the tumult of the past few months, we have reached inside ourselves and mobilized our teams to do what seemed to be the impossible. While I have always known that the DNA of great leaders is a unique combination of talent, ambition and a passion to do what's right, I have never witnessed such a persuasive display. My hope for our patients and field is that with our newfound knowledge and the will to make progress in reducing disparities, we will make even greater progress to advance not only our capacity to lead, but the care we provide to those who need us most. What you do inspires me and gives me great hope for our future. Thank you. ▲

Deborah J. Bowen, FACHE, CAE, is president and CEO of the American College of Healthcare Executives (dbowen@ache.org).

TOP
5

Approaches to
**Physician
Satisfaction**



Advice for times of crisis and for every day

By Laura Hegwer

Healthcare executives cannot let their guard down on physician satisfaction even during an unprecedented event like the COVID-19 pandemic. Even in areas that have been less devastated by COVID-19, healthcare executives may wonder how to best preserve their valued relationships with physicians as they cope with the ramifications of the global emergency.

Whether hospital operations are business as usual or upended because of a crisis, it's imperative that healthcare executives stay focused on physician satisfaction, engagement and well-being, according to experts. "Caring about professional well-being is the way that organizations are going to best achieve the other outcomes that they are working toward, including safety, patient satisfaction, quality of care and the financial stability of the organization," says Christine A. Sinsky, MD, a general internist and vice president of professional satisfaction at the American Medical Association.

As affiliations between physician practices and health systems continue, focusing on physician satisfaction and engagement may help executives address financial challenges and staff shortages that threaten patient care and their organizations' sustainability, according to a 2017 study, "Executive Leadership and Physician Well-Being," published in *Mayo Clinic Proceedings*.



TOP Approaches to Physician Satisfaction

Following are strategies for improving physician satisfaction, even during challenging times.

1 Create a culture that respects physicians and their well-being. Prior to the pandemic, only half of physicians said they had a positive relationship with administrators, according to a 2019 survey of more than 5,000 physicians from multiple specialties by the American Academy of Family Physicians and the staffing company CompHealth. In the same study, only 31% of physicians reported that their organizations prioritized physician well-being. At the time of this writing, no large surveys of physician satisfaction with hospital leaders had been completed during the COVID-19 crisis.

To improve physician relationships, healthcare executives should create the kind of workplace in which all leaders make physician satisfaction and well-being a priority, experts say. Rather than being reactive to

physician concerns, leaders should adopt a more proactive—even strategic—approach. “The CEO has to create a supportive culture for physicians, not just keep them from getting upset,” says Thomas H. Lee, MD, CMO, Press Ganey.

In its “Joy in Medicine” resources, the AMA refers to the ideal workplace environment as having a “culture of wellness,” which values self-care, personal and professional growth, and compassion. In organizations with such cultures, leaders have shared accountability for physician wellness. They include physician satisfaction as part of their strategic plan. They also may make a portion of top executives’ annual compensation dependent on the well-being, satisfaction or engagement scores of their physician workforce, Sinsky says.

In organizations that have embraced this kind of culture, leaders and physicians also share the same values and work in concert to deliver safe, coordinated and empathic care, Lee says. When leaders and physicians are aligned this way, organizations tend to have lower turnover and better health outcomes, including

fewer readmissions and a shorter length of stay, he adds. (That said, he thinks it is a mistake to use financial incentives to align physicians to the organization’s quality improvement goals. “It can send the wrong message by suggesting that there’s a threshold and if physicians just get there, that’s good enough,” he says.)

The AAFP/CompHealth survey also found that only one-third of physicians felt appreciated for their work, suggesting that even during normal operations, many healthcare executives may miss opportunities to show their respect and gratitude to the medical staff.

“Caring about professional well-being is the way that organizations are going to best achieve the other outcomes that they are working toward, including safety, patient satisfaction, quality of care and the financial stability of the organization.”

—Christine A. Sinsky, MD
AMA

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TOP 5 Approaches to Physician Satisfaction

Resources to Improve Physician Satisfaction

Healthcare Executive Magazine ([HealthcareExecutive.org](https://www.healthcareexecutive.org))

"Sustaining Performance With Nudges," January/February 2020 *Healthcare Executive*.

"Battling Clinician Burnout: Fighting the Epidemic From Within," January/February 2019 *Healthcare Executive*.

"Retaining Your Most Valued Resource: Appreciated High-Value Staff Improve Patient Care," January/February 2019 *Healthcare Executive*.

Health Administration Press Books ([ache.org/HAP](https://www.ache.org/HAP))

Developing Physician Leaders for Successful Clinical Integration

Inside the Physician Mind

ACHE Assessments ([ache.org/CareerResources](https://www.ache.org/CareerResources))

Emotional Intelligence Assessment

Change Management Leadership

Additional Resources

AAFP's **Physician Health First** portal provides resources to help physicians boost their practice efficiency, build leadership skills, practice self-care and more.

AMA's "**Creating the Organizational Foundation for Joy in Medicine**" module, co-authored by Christine A. Sinsky, MD, offers guidance on implementing a culture of wellness and efficiency.

AMA's "**Getting Rid of Stupid Stuff**" module helps physicians reduce inefficient EHR tasks and regain control of their day.

The Institute for Healthcare Improvement's "**Framework for Improving Joy in Work**" white paper provides ideas for improving clinician satisfaction and engagement.

For some physicians, working with an organization that has a culture that respects its professional staff is just as important as compensation, says Clif Knight, MD, FAAFP, senior vice president of education, AAFP. "Sometimes, compensation becomes a proxy if physicians don't feel appreciated or respected, and they focus on how much they get paid," he says. "But if physicians feel appreciated and respected by the organization, that goes a long way in helping them feel a sense of satisfaction and connection to the organization."

2 Reduce the inefficiencies that irk physicians.

According to the AAFP/Comp Health study, clerical duties and administrative issues are the top tasks that hinder physician happiness at work.

"The physician workforce in this country is not working at full power," AMA's Sinsky says. "Physicians are working extensively, but we are misusing a lot of those hours on work that does not require a medical school education." She believes that in most organizations, physicians could save three to four hours per day by redistributing clerical and lower-level clinical tasks to other members of the patient care team. Strategically delegating tasks also would decrease the amount of work that physicians need to do at home after normal business hours—what Sinsky refers to as "pajama time"—that is a major contributor to burnout and dissatisfaction.

EHRs are another major source of physician dissatisfaction. Sinsky co-authored a March 2020 study, “The Association Between Perceived Electronic Health Record Usability and Professional Burnout Among US Physicians,” published in *Mayo Clinic Proceedings*, that found a strong dose-response relationship between EHR usability and physician burnout. In terms of usability, EHRs ranked below common technologies like Excel spreadsheets and global positioning systems, according to physicians surveyed.

Many EHRs include redundancies that can make the day-to-day practice of medicine maddening. For example, Sinsky found that it took 32 clicks in her own EHR to order and record giving a patient a flu shot.

Some healthcare organizations are actively working to address such issues. For example, leaders at Hawaii Pacific Health in Honolulu implemented a “Getting Rid of Stupid Stuff” program, in which employees submit their ideas to reduce inefficient documentation practices. Their early successes were described in a November 2018 article in *The New England Journal of Medicine*.

Leaders can also consider technology investments like larger monitors, which reduce physicians’ cognitive workload because they can see more information on a single screen. Using badge logins, rather than requiring usernames and passwords, also helps save time and eases the burden of technology, according to Sinsky.

3 **Be an accessible and transparent leader.** Whether leaders are in the midst of a crisis or managing business as usual, they need to make themselves available to physicians, says AAFP’s Knight.

At Memorial Hospital in Jacksonville, Fla., Bradley (Brad) S. Talbert, FACHE, president and CEO, rounds frequently with his leadership team. “I want to be visible,” he says. “I want the physicians to see my face and the faces of our executive team and be able to interact, share ideas and collaborate.” He even provides physicians with his cell phone number and encourages them to reach out to him directly.

With most of the 800 providers on his medical staff still in private practice, Talbert acknowledges that their needs may be different from the hospital’s needs. “It’s important that we listen and have an open dialogue so we can try to find those common-ground areas on which to collaborate,” he says.

Even during difficult times like the pandemic, he aims to be as open as possible with his medical staff. “We want to be as transparent as we possibly can at all times because that ultimately builds trust,” he says, “and when you have trust, you can have really strong relationships.”

Talbert credits these relationships for helping improve physician engagement. In his hospital’s most recent survey, 85% of the medical staff identified as “highly

“I want to be visible. I want the physicians to see my face and the faces of our executive team and be able to interact, share ideas and collaborate.”

—Bradley (Brad) S. Talbert, FACHE
Memorial Hospital



TOP Approaches to Physician Satisfaction

engaged” or “very engaged.” Since he joined the organization in 2017, the hospital also has improved how many physicians believe the hospital is an excellent place to practice medicine, moving from the bottom 10th percentile to the 67th percentile nationally.

“We’re not satisfied with that number, but it’s a tremendous improvement,” he says.

4

Give physicians a voice in capital allocations for new services and technology.

Healthcare leaders can improve physician satisfaction by working collaboratively with their medical staff to shape the organization’s investments and capital strategies, Talbert says.

A few years ago, some surgeons on staff at Memorial Hospital were disappointed by the hospital’s lack of sustained investment in robotic surgery. Although it was one of the first hospitals in the area to offer robotic surgery, leaders had failed to continue investing in and promoting the technology.

“The most important thing about surveying physicians is that you have a plan for what you’re going to do with that information.”

—Clif Knight, MD, FAAFP
AAFP

After speaking with the surgeons, Talbert and his team invested in two new surgical robots and made expanding the program an organizational priority. Since then, the hospital has seen a rapid growth in robotic procedures, from about 15 cases per month to nearly 100 cases per month. “We’ve had numerous physicians join the medical staff to take advantage of that,” Talbert says. “It’s been a real strong success story for the physicians, for the hospital and, ultimately, the patients.”

5


Turn survey results into action.

“The redesign of healthcare delivery has been accelerating for a long time, and the pandemic just makes it that much more dramatic,” says Lee of Press Ganey. In times of rapid change, like the industry is currently experiencing, Lee believes healthcare executives should survey their physicians more frequently than once every two or three years.

While more frequent surveys can provide valuable insights, it’s important for leaders to remember that physicians suffer from survey fatigue, says AAFP’s Knight. “The most important thing about surveying physicians is that you have a plan for what you’re going to do with that information,” he says.

During normal operations, and especially in times of crisis, it is critical for healthcare executives to acknowledge and address physicians’ concerns if they want to build trust. Experts say doing this and following other physician satisfaction practices can drive better outcomes—particularly when organizations need it most.

Laura Hegwer is a freelance writer and editor based in Lake Bluff, Ill.



Implementing Strategies and Developing Resources That Address COVID-19 Challenges

The coronavirus disease 2019 (COVID-19) has communities on high alert, and Envision Healthcare's more than 27,000 clinicians are leading efforts to care for patients and support our organization's hospital partners through the implementation of clinical best practices.

The health and well-being of patients and clinicians are our priority. As information on the coronavirus evolves, we will continue to evaluate our response and work with healthcare system partners to provide patients in communities across the nation the highest quality of care.

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—Bonnie O’Meara

Vice President, Talent Management
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Ann Arbor, Mich.

With our current environment of increased uncertainty due to COVID-19, today’s healthcare organizations must fulfill their duty to take care of their providers so they, in turn, can take care of the patients at the heart of the healthcare system. A comprehensive, systems approach to addressing clinician well-being may be the key for healthcare organizations to achieve real, positive change that reverberates throughout their clinician populations and improves patient care and outcomes.

As an emergency medicine physician, Stefanie Simmons, MD, vice president of Patient and Clinician Experience at Envision Physician Services and an ACHE Member, knows from first-hand experience and through her studies the stressors associated with providing care in today’s healthcare system. The clinical environment changes rapidly, from heightened administrative responsibilities to new clinical challenges—as seen with COVID-19—and clinicians’ ability to maintain their personal and professional well-being is paramount for their personal health and their ability to care for patients.

“Keeping clinicians safe and healthy is critical to treating all patients and ensuring clinicians’ long-term ability to deliver patient care in the communities they serve,” Simmons says.

In the practice of medicine, clinicians are consistently exposed to trauma and stressors on the job. While they have training

and experience managing difficult situations, they are still human and are not devoid of emotion or immune to stress.

With Simmons leading the way, Envision, a national medical group, put in place several wellness initiatives to support the health and well-being of more than 27,000 clinicians who are on the front lines of patient care.

Wellness Champions Program

Among the many initiatives established is the Wellness Champions Program, which provides clinician peer-to-peer support. The program provides an opportunity for clinicians to connect with colleagues who understand the many demands of practicing in today’s healthcare system and want to promote the personal and professional growth of their peers.

Wellness Champions receive four hours of mental health training so they are more adept at identifying, supporting and referring colleagues who may be going through a difficult time. They then receive four additional hours on how to execute the wellness program, which encompasses smaller programs tailored to different topics. Following the training, Wellness Champions choose a specific subprogram to support at their worksite and implement it. The goal is to have one Wellness Champion at each of Envision’s sites.

“We didn’t just want a top-down, impersonal program; we really wanted to involve clinicians’ peers,” Simmons says.

One way the Wellness Champions have done this is through a specific communications subprogram that engages a team of clinical and nonclinical experts who work together to develop solutions that remove barriers to patient care.

“Every day our clinicians go to work in our complex medical system, they are climbing up a mountain,” Simmons says. “Now imagine you have a pebble in your shoe, and you’re trying to

climb that mountain—it makes it 10 times harder than it needs to be.” In the program, Wellness Champions solicit feedback from their clinician colleagues via a Pain Points Survey about any obstacles. Wellness Champions then analyze the survey results and collaborate with leaders across Envision on solutions.

Practicing What They Preach

The Wellness Champions Program is a natural extension of one of the medical group’s core values: to create an environment of engagement in which clinicians are valued and feel passion and joy for what they do. “This program is practicing what we preach,” says Bonnie O’Meara, vice president, Talent Management, Envision Physician Services. “We want clinicians to know we have their backs.”

Simmons and O’Meara believe a “systems approach” to addressing clinician wellness is essential for success. The idea aligns with a 2019 report by the National Academy of Medicine, *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*, which calls upon healthcare leaders to emphasize training and clinician support to improve professional well-being for the benefit and overall health of clinicians, patients and communities around the nation. (Recommendations from the report are available at nam.edu.)

Working collaboratively across departments, and by leveraging resources they have within their own systems, healthcare organizations can set the stage to improve clinician wellness.

“It’s one of the hardest professions on the planet—to be all in with their minds and their hearts, with all of the other pressures that are swirling around them,” O’Meara says. “As a society, we owe it to clinicians to look out for them.”

The Wellness Champions Program’s support extends beyond its 27,000 Envision colleagues, as many are sharing the benefits of the program with their hospital partner

colleagues. Training for the first 300 identified Wellness Champions was underway. Then, COVID-19 hit.

COVID-19 Initiatives

Regardless of their specialty, COVID-19 has disrupted clinicians’ normal practices. As the public health crisis evolved, Envision rapidly adjusted and expanded its wellness efforts, providing resources and a structured approach to support all employees—both clinicians and nonclinical team members—to help them navigate the disruption caused by the coronavirus. These efforts include:

- Daily wellness coaching and stress management support for clinicians and support team members that focus on community support and conclude with a five-minute guided meditation.
- Peer crisis support training designed to train clinicians, clinical leaders and clinician supporters on crisis resources, peer support and signs a colleague may be struggling.
- Counseling and follow-up sessions for clinicians who have been deployed to or work in COVID-19 hot spots to help them debrief and prepare for reintegration back home.

As the COVID-19 pandemic progresses, Simmons says Envision will continue to support clinicians, care for patients and work to mitigate the spread of the virus.

For more information, please contact Stefanie Simmons, MD, vice president, Patient and Clinician Experience, Envision Physician Services, at stefanie.simmons@envisionhealth.com.

COVID-19 Resources

During this unprecedented and challenging time in healthcare, clinicians need even more wellness resources and support than ever. For a collection of resources related to caring for patients with COVID-19, visit envisionhealth.com/covid-19ACHE.

Behavioral Healthcare

Now and **Post COVID-19**

Integrating Telemental Health Services

By Susan Birk

The soaring incidence of mental health problems triggered by COVID-19 and the resulting precipitous economic downturn, combined with the social distancing required to curb the coronavirus' spread, have thrust telemental health into the spotlight.

When the pandemic hit, hospitals and health systems had to move within days or weeks to a virtual model to continue psychotherapy and psychiatric management for patients and reduce the risk of suicide attempts, ED visits and hospitalizations. Now that many organizations have made the transition, early signs are that this option will last.

An encouraging example can be seen at CHI Health Immanuel, Mercy and Lasting Hope Recovery Center, Omaha, part of a 14-hospital network serving Nebraska and southwestern Iowa. It saw virtual behavioral health visits during the first month of the pandemic rise to 85% (from 2%) of encounters and the no-show rate drop to less than 10% (from 23%).

“We hope the temporary regulatory changes ensuring telehealth access due to COVID-19 will remain in place,” says Ann M. Schumacher, RN, FACHE, president, CHI Health Immanuel and Lasting Hope Recovery Center, and CHI Mercy Council Bluffs, Iowa. “Behavioral health translates well to the virtual platform and eliminates many of the barriers, including stigma, that may stop patients from following up with treatment. Patients appreciate their ability to access timely and safe services.”

Not surprisingly, telehealth, already on the rise in many specialties, has shown value as a delivery tool for emerging behavioral health models. It offers convenience for patients, brings services to people in remote





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areas or for whom travel is difficult, and allows clinicians to transport themselves remotely, on demand, to emergency rooms and inpatient units for consultations.

“When it comes to integrating behavioral health into service offerings, telehealth also provides a pathway for organizations that want to develop more robust behavioral health programs but lack the staff to do so,” says Howard J. Gershon, LFACHE, founding principal of New Heights Group, Santa Fe., N.M. “Telehealth allows organizations to expand their treatment capacity.”

Jay H. Shore, MD, director of telemedicine at the Helen and Arthur E. Johnson Depression Center, University of Colorado Anschutz Medical Campus, and chair of the American Psychiatric Association’s Committee on Telepsychiatry, notes that, “like anything in medicine, there are complexities involved in implementing telepsychiatry, but as a field, it has matured, and especially since COVID, it is coming to the mainstream. My assumption is that we’ll have more virtual options once COVID ends—hybrid care that will include in-person visits as well as videoconferencing, phone, patient portal and email communication. We’ll see more technology in care going forward, and each

“Behavioral health translates well to the virtual platform and eliminates many of the barriers, including stigma, that may stop patients from following up with treatment.”

—Ann M. Schumacher, RN, FACHE
CHI Health Immanuel and
Lasting Hope Recovery Center,
and CHI Mercy Council Bluffs

system and practitioner will go through their own process of figuring out the optimal blend.”

A silver lining with COVID-19 is the fact that mental health is receiving heightened attention, Gershon observes. “People are learning that telesolutions in mental health services are readily available and work well. This shot in the arm will help us use these options to treat more people,” he says.

Following are profiles of three organizations that have used virtual technology to broaden their behavioral health services in some innovative ways, both before and during the pandemic.

Providence St. Joseph Health: Optimizing Resources With Telecare

With 51 hospitals in seven states, and as the parent organization for 100,000 caregivers, Providence St. Joseph Health is large. But it faces the same high demand for mental health services and shortage of psychiatrists seen across the U.S. The system has responded with a model built around the judicious use of psychiatrists as members of a collaborative care team that is integrated into primary care practices. Virtual visits are the foundational mode of delivery.

Telebehavioral health was introduced as an option 10 years ago at a handful of the system’s suburban and rural hospitals, where need was greatest. Since 2016, the system has been offering virtual services at 35 hospitals, and further expansion is planned.

“We’ve headed decidedly away from a traditional one doctor, one patient relationship to a multidisciplinary approach that includes on-demand service with a counselor or nurse practitioner with psychiatrist backup,” says Todd Czartoski, MD, chief medical technology officer for telehealth. “We use social workers and other allied health professionals to spread the expertise. The important part is connecting patients to the ecosystem so that if someone does need a psychiatrist, we can seamlessly make that referral.”

Embedding psychiatrists into primary care practices via virtual care works well because “primary care is

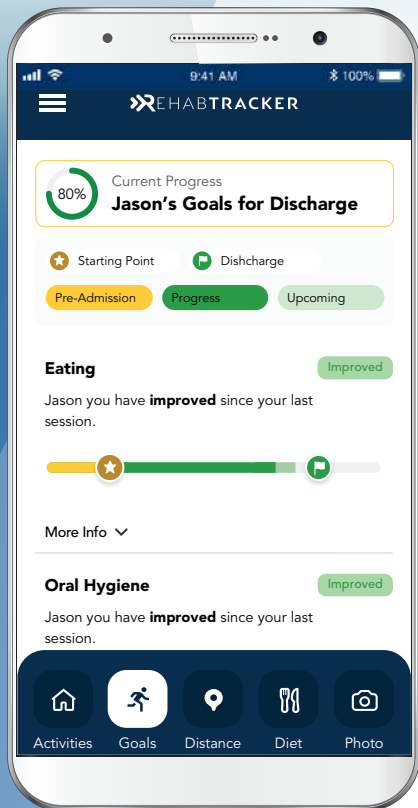


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where most behavioral healthcare really occurs,” Czartoski notes. “The best ER visit for a mental health issue is the one that never happens. It’s the one you can prevent by seeing people before they go into crisis.”

Layered in with these ambulatory offerings are self-service digital tools that help patients monitor their condition. The apps drive additional cost efficiencies. “We’re not eliminating psychiatrists; we’re adding digital resources to free psychiatrists to care for larger populations,” Czartoski says.

A second major initiative at Providence St. Joseph is a service for employees and their families called Behavioral Health Concierge, an on-demand help line with a record of responding quickly to employees’ needs since its rollout a year ago. Czartoski reports that 65% of people are seen within 24 hours.

Developed partly in response to some physician suicides within the organization, the service sees 400 individuals monthly and continues to fill a vital need during the pandemic. “Physicians are notoriously reticent to ask for help, but 21% of the people using the concierge are physicians,” he says.

Czartoski says virtual visits enhance the patient experience rather than detract from it. He reports that patient satisfaction scores at

“Like anything in medicine, there are complexities involved in implementing telepsychiatry, but as a field, it has matured, and especially since COVID, it is coming to the mainstream.”

—Jay H. Shore, MD
Helen and Arthur E. Johnson
Depression Center
University of Colorado
Anschutz Medical Campus

Providence St. Joseph for telemental health have consistently been higher than in-person visits.

Virtual care has been particularly meaningful during the pandemic. “For patients in a COVID isolation unit who haven’t seen a person with an unmasked face in 10 days, a remote visit with a psychiatrist during which masks are not required can be a more intimate experience than if the psychiatrist were in the room,” Czartoski says.

Tanner Health System: Virtual Continuity Lowers Recidivism

Before COVID-19, Carrollton, Ga.-based Tanner Health System’s

involvement in telepsychiatry revolved around the use of a third-party service to cover the nonprofit five-hospital system’s EDs and floors. The behavioral health division at Willowbrooke at Tanner, the system’s inpatient behavioral health facility, provided telepsychiatry for the system’s more remote campuses.

When COVID-19 hit, Willowbrooke moved its psychiatrists from in-person inpatient care to daily teleporting from home. The reduced “windshield time” afforded by the shift allowed the psychiatrists to assume responsibility for the consult service that was being handled by the outside vendor, reports Wayne Senfeld, EdS, senior vice president for behavioral health.

While the use of telepsychiatry during the COVID-19 crisis “hasn’t been optimal for every patient, it has provided a very good alternative and enabled us to manage our patients effectively,” he says.

Senfeld, who chairs the Psychiatry Committee of the Georgia Hospital Association, notes that Willowbrooke is the only behavioral health hospital in the state he knows of that continued providing both inpatient and outpatient services without interruption during COVID-19 using telehealth.

The wider utilization of virtual care catalyzed by COVID-19 has also had the unanticipated benefit of allowing the same psychiatrist that treated a patient remotely during their inpatient stay to continue seeing that

patient remotely after discharge without a break in continuity of care, notes Kenneth Genova, MD, Willowbrooke's executive medical director.

Because the hospital serves as a behavioral health services provider for a large swathe of Georgia, including a sizeable share of the state's indigent people, some of whom might live two or more hours away, it hadn't been practical for the same providers who'd treated a patient during their hospitalization to continue seeing them for outpatient care.

That changed with the pandemic. "Until the world gets to a calm place where local psychiatric services can be accessed more readily, we're taking care of everybody that we see from the moment they hit the ERs all the way back to their communities," Genova says. "The change to virtual delivery during COVID has reduced recidivism by enabling our inpatient level of care to be extended to more patients on an outpatient basis."

Though Willowbrooke's practitioners all transitioned successfully to telehealth, some adapted exceptionally well. Their ease with virtual medicine will be tapped to help the hospital build a full-scale telepsychiatry service, Genova says.

Genova sees potential for organizations that eliminated their behavioral health programs years ago to begin offering mental health services again through telepsychiatry. "What's to stop

"We've headed decidedly away from a traditional one doctor, one patient relationship to a multidisciplinary approach that includes on-demand service with a counselor or nurse practitioner with psychiatrist backup."

—Todd Czartoski, MD
Providence St. Joseph Health

an established, well-staffed behavioral health program from tele-reporting practitioners to a smaller or even a larger hospital that doesn't have the same depth of expertise?" he says.

Genesis PrimeCare: Remote Therapy for Underserved Populations

Genesis PrimeCare, Marshall, Texas, a seven-site network of primary and specialty care clinics, is among the 82 healthcare organizations that have received funding so far under the Federal

Communications Commission's COVID-19 Telehealth Program.

The program is distributing \$200 million appropriated under the Coronavirus Aid, Relief, and Economic Security Act to help non-profit and public eligible healthcare providers address care access issues related to the pandemic by developing new or expanded telehealth capabilities. As of mid-May 2020, when Genesis PrimeCare was announced as a recipient along with 32 other organizations, the program had distributed \$33 million in funding.

Genesis PrimeCare received \$990,000 to expand telehealth and remote patient monitoring services for primary, pediatric and behavioral health-care for low-income and

46.6
MILLION

Americans in 2017 experienced mental illness in a given year (one in five).

Source: National Institute of Mental Health

13.5 MILLION

adults had an unmet need for mental health services, and 20% encountered a roadblock to accessing care.

Source: Association of American Medical Colleges



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underserved communities in rural northeast Texas.

In the behavioral health space, that funding has been used to support the

organization's journey from all on-site therapy and counseling services to an environment in which 90% of visits are now done remotely.

"While we're eager to get some patients back into the clinic when it is safe for certain types of therapy that are more conducive to being on-site—such as eye movement desensitization and reprocessing therapy for post-traumatic stress disorder—our patients love the televisits, and our providers feel they're able to meet their patients' needs," says Carla Roadcap, CEO.

"The virtual visits have helped many people feel less isolated during the pandemic. Telehealth allows us to continue encouraging patients to practice their healthy coping mechanisms. It's working."

—Carla Roadcap
Genesis PrimeCare

The organization faced some challenges during the transition. Many of the behavioral health patients were initially uncomfortable with the idea of not being in the same room with their therapist. To gently raise their comfort level, the practitioners began

by having educational conversations with the patients, followed by brief teletalks—informal chats, not therapy sessions—so patients could get a taste of videoconferencing. "All of our patients were pleased with this option once they tried it," Roadcap says. "And their transportation issues are gone."

Patients whose children were a distraction during therapy appointments were encouraged to let their children watch a movie or engage in an activity to free their parents to focus on their session. "Many patients have indicated they would like to continue with virtual therapy because they no longer have to arrange and pay for childcare for their appointments," Roadcap says.

Dedicated patient service representatives at three of Genesis PrimeCare's locations handle telehealth appointment scheduling and help patients work through any technical glitches before their therapy sessions begin. The organization's IT department steps in occasionally to assist some patients who lack sufficient internet connectivity.

Despite some patients' initial hesitation, "the virtual visits have helped many people feel less isolated during the pandemic," says Roadcap. "Telehealth allows us to continue encouraging patients to practice their healthy coping mechanisms. It's working."

Susan Birk is a Chicago-based freelance writer specializing in healthcare. Lea Radick, writer, Healthcare Executive, contributed to this article.





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On the Horizon: Precision Medicine's Wider Reach

Valuable partnerships can help organizations achieve benefits and mitigate challenges.

“My hope is that 10 years from now, we will look at precision medicine just as we did when imaging and other technologies first became mainstage—that it becomes a ubiquitous thing that we do.”

—Milan Radovich, PhD

Associate Professor of Surgery, Medical/Molecular Genetics/Vice President of Oncology Genomics
Indiana University Health
Indianapolis

Precision medicine is one of medicine's most promising areas. But though the strategy—tailoring medical treatment to an individual patient's needs rather than using a one-treatment-fits-all approach—has been around for many years, successful implementation has so far only been achieved by a handful of large health systems. This can all change, however, in the coming years if today's healthcare organizations can overcome obstacles to adopting precision medicine, including by seeking innovative collaborations.

Precision Medicine's Rise

An emergence of cutting-edge technology has thrust precision medicine more into the spotlight in recent years, according to Bryan Schneider, MD, Vera Bradley Chair of Oncology, professor of medicine and medical/molecular genetics, and co-leader of the Indiana University Precision Health Initiative at Indiana University Health, Indianapolis. “We've tried for many years to get the right drugs to the right patients while minimizing side effects,” Schneider says. “But there has been an evolution of technology that has allowed us to now do this at a markedly greater depth.”

Use of cutting-edge technology, such as genomic sequencing, can have innumerable benefits for patients. “When we can match a patient's tumor genome to the right drug,

we're trying to improve survival,” says Milan Radovich, PhD, associate professor of surgery, medical/molecular genetics, and vice president of oncology genomics, Indiana University Health. “Data show that genomic technology improves outcomes. It also helps us understand some of the etiology of where the disease came from, particularly in those patients who are born with mutations that they inherited that predispose them to developing the disease in the first place. We want to be able to help those patients' relatives, for example, if cancer runs in the family.”

Enthusiasm for this type of care is high among patients as it becomes more popular. “It's not uncommon these days for patients to come into clinics to see oncologists and say, ‘I've read about it in the news—how do I get access to this technology?’” Radovich says.

Seek Out Partnerships

There are steps organizations of all sizes can begin to take toward developing a precision medicine strategy and making this care approach more widely available. One such step is partnering with cutting-edge technology vendors.

“The technology is advancing at breakneck speed, so working with vendors that supply particular technologies to a wide swath of users and who themselves are keeping that technology up to date is very beneficial,” Schneider says. Because of its relationship with supplier partners, Indiana University Health's precision medicine program is able to deploy a vast array of technologies in its diagnosis and treatment of patients, including genomic sequencing, liquid biopsies, cloud-based IT and more.

Tailoring care to individual patients—the heart of precision medicine—requires a broad portfolio of testing and monitoring techniques, something Roche Diagnostics Corporation knows well.



"We think in terms of all diagnostic and monitoring modalities and how can we incorporate that together to take the best care of the patient," says Alan Wright, MD, CMO. "It's really about the patient's journey, from health into sickness and back to health."

With precision medicine, each phase of a patient's treatment journey is customized to that patient, from diagnosis to treatment selection and risk stratification, all the way through to relapse detection. "There's a lot of data points there, and a lot of information to coordinate," Wright says.

Having access to the latest, most reliable testing technologies and being able to pull it all together based on a patient's unique needs is vital to advancing patient care, research and clinical implementation. "The partnership with vendors always starts with having incredibly impeccable testing capabilities that we can be comfortable with because when we think about the results of these tests, they're going to impact ultimately what drug a patient gets, and in many ways that's a life or death decision," says Schneider. "In addition, partnerships are really what allow us to push technology and the clinical implementation of that technology to the next level."

Form Community Collaborations

Another path to expanding precision medicine is for smaller, community-based healthcare provider organizations to partner with existing precision medicine programs. Indiana University Health's program includes four clinics across the state, with three in rural areas. The university's staff members work with clinic staff on interpretation, database matching, bioinformatics and more.

"This model allows us to distribute our university expertise and to provide an unprecedented level of access, as most patients are seen within a week of referral at the expansion sites," Radovich says. "The future state of precision medicine,

in my opinion, is not the community centers trying to do what academia does. It's bringing the expertise and distributing the technology to them so there is a blend."

One of the numerous benefits of these collaborations is expanding patient access to new drugs and clinical trials, which community healthcare sites often cannot access. "To me, one of the most disheartening things is to give hope to a patient by applying this cutting-edge technology, getting a result and then saying, 'To get this, you have to drive five hours away,'" says Radovich.

Are there barriers to making precision medicine more widely available? Yes. But are those hurdles insurmountable? For Schneider and Radovich, the answer is a hopeful "No."

"I think there are some definite hurdles, but I think they can be overcome," Schneider says.

Adds Radovich, "My hope is that 10 years from now, we will look at precision medicine just as we did when imaging and other technologies first became mainstage—that it becomes a ubiquitous thing that we do."

For more information, please contact Cari Nicholson, marketing manager, Roche Diagnostics Corporation, Indianapolis, at cari.nicholson@roche.com.

COVID-19 Resources

Roche Diagnostics has resources available to healthcare providers for navigating the evolving challenges of COVID-19. Please visit <https://diagnostics.roche.com> for more information.

Note: This advertorial was developed prior to the unfolding COVID-19 crisis.



Paul B. Hofmann, DrPH,
LFACHE

Empathy's Role in Improving Resiliency

Genuine compassion can help heal staff members and patients.

Given the unprecedented impact of the coronavirus pandemic, accelerating steps needed to elevate empathetic behavior is especially important. A psychologically safe and just culture will assist staff and patients in coping more effectively when uncertainty and fear are so ubiquitous. There is no panacea, but each incremental effort will be worth the investment.

In her notable 2013 TED Talk, Harvard professor and psychiatrist

Helen Riess, MD, provides several breathtaking examples of human empathy (see sidebar below). During the talk Riess says, "The good news about empathy is that when it declines, it can also be learned. Employers who want to have an engaged and productive workforce need to get tuned into the people. Patients who don't feel cared about have longer recovery rates and poor immune function."

During an extended phone conversation I had with Riess early this year, she emphasized that the qualities of empathy are teachable and, eventually, lead to an improvement in staff attitudes and behavior.

More recently, she told me, "During the COVID-19 pandemic, empathy is needed more than ever at every level of healthcare organizations. Our patients need greater empathy because of the increased threats to their safety, and our colleagues need support and permission to ask for help that may be difficult for them."

Riess created the acronym E-M-P-A-T-H-Y to help us remember the key pieces of how we connect to people. In the TED Talk, she describes:

- The "E" represents eye contact. Every human being, Riess says, "has a longing to be seen, understood and appreciated."
- The "M" represents facial expression muscles. Riess suggests our faces are actually a road map of human emotion that can rarely be completely hidden.
- The "P" represents posture. Riess indicates "posture is another powerful conveyor of connection." She cites a widely publicized study (*Journal of Pain and Symptom Management*, May 2005) in which researchers at MD Anderson Cancer Center in Houston found that physicians who were asked to sit down when making rounds in a patient's room were rated as being much warmer and more caring and were estimated to have spent three to five times

The Power of Empathy

Harvard professor and psychiatrist Helen Riess, MD, works at Massachusetts General Hospital and is the co-founder, chief scientist and chair of Empathetics Inc. Her remarkable 2013 TED Talk, "The Power of Empathy," has been viewed over 500,000 times.

During the talk, Riess mentions having received a request from one of her students who wanted to determine if, when there is empathy between people, their heart rates and other physiological tracers become concordant. The student also wanted to recruit doctor-patient pairs who were willing to have their sessions videotaped and be hooked up to monitoring devices during those sessions. Riess approved the project, participated in it and, in the TED Talk, explains how she became a more effective therapist as a result of analyzing the videos. According to Riess, the familiar statement, "I feel your pain," is actually validated by neuron studies of the brain.

This experience led her to learn everything she could about the neuroscience of empathy which, in turn, motivated her to develop empathy training grounded in the neurobiology of emotions and empathy. The training was evaluated in a randomized control trial where those doctors trained in empathy were reported by patients as being better listeners, showing more compassion and better understanding patient concerns.

longer with their patients than doctors who remained standing, even though both sets of physicians spent the same amount of time with patients.

- The “A” represents affect. Physicians are trained to evaluate a patient’s affect as a way of assessing the person’s emotional state.
- The “T” represents tone of voice. According to Riess, the nuclei for tone of voice and facial expression reside in the same area of our brain stems. “This means that when we are emotionally activated, our tone of voice and our facial expressions change without our even trying,” Riess says. With practice, Riess notes, we can become more capable of hearing and seeing what these emotions are.
- The “H” represents hearing the whole person. “Far more than the words that people say, hearing the whole person means understanding the context in which other people live,” Riess says.
- The “Y” represents one’s response to others’ feelings. “We respond to other people’s feelings all the time,” Riess says. “We might think that we only experience our own emotions, but we’re constantly absorbing the feelings of others.”

The Importance of Unhurried Conversations

The article “Careful and Kind Care Requires Unhurried Conversations,” published in the Oct. 29, 2019, issue of *NEJM Catalyst*, highlights a similar theme. According to the authors,

“To enable unhurried conversations, whether face-to-face, via telemedicine, asynchronous or virtual, participants need to make themselves cognitively and emotionally available.”

.....
Any program that promotes empathy and benefits patients as well as staff by increasing their resiliency in the face of pandemics, illness, trauma or occupational stress should be pursued vigorously.
.....

It is true that the term “unhurried conversations” implies that such discussions will take more time than perhaps is desired when there are intense pressures on clinicians to increase productivity, see more patients and become more efficient. However, reality and perception are not always aligned. This familiar adage was confirmed by five noteworthy articles: the previously cited 2005 issue of the *Journal of Pain and Symptom Management*; a 2011 issue of *Patient Education and Counseling*; a 2016 issue of the *Patient Experience Journal*; a 2016 issue of the *Journal of Hospital Medicine*; and a 2017 issue of the *Journal of Nursing Care Quality*. Each article reported the results of studies that consistently demonstrated that patients perceived doctors and nurses spending more time with them than other clinicians when the staff member simply sat down.

In an article I co-authored with Jeffrey Selberg in the January/February 2006 issue of *Healthcare*

Executive, we recommended several steps that should be taken to promote a culture of empathy. At least three deserve re-emphasis:

- Establish objective performance indicators, standards and goals regarding patient-centered care; monitor results; and routinely report findings to senior management, medical staff leadership and board members.
- Create opportunities for patients and family members to promote quality healthcare and improve workflow processes by serving on hospital advisory committees.
- Insist that senior executives make regular patient rounds to remind them of the value of interacting directly with patients and staff on clinical units.

Given our experience with COVID-19, we know resources and time are going to be insufficient to meet the needs of every clinician. Consequently, any program that promotes empathy and benefits patients as well as staff by increasing their resiliency in the face of pandemics, illness, trauma or occupational stress should be pursued vigorously. ▲

Paul B. Hofmann, DrPH, LFACHE, is president of the Hofmann Healthcare Group, Moraga, Calif., and co-editor of Management Mistakes in Healthcare: Identification, Correction and Prevention, published by Cambridge University Press and Managing Healthcare Ethically: An Executive’s Guide, published by Health Administration Press (hofmann@hofmannhealth.com).



K. Joanne McGlown,
PhD, RN, FACHE

Healthcare's Emerging Reality Post COVID-19

Changes will be seen across many areas, including patient experience.

As this article went to press, there were still many unknowns. Predictions of potential new waves of the COVID-19 virus into 2021 seemed likely to come true, compounded by interaction with the normal flu season. Here is a generalized industry assessment of the emerging reality and what our altered health system might look like in light of COVID-19.

Changing Patient Expectations

Though some have predicted this crisis will crush the hospital industry in the short term, few would argue that it will not change the field drastically in the future. “The reported demise of hospitals is on hold for the time being. COVID-19 has taught us that hospitals are essential to respond to important environmental jolts,” says Leonard Friedman, PhD, FACHE, professor, Department of Health Policy and Management, and director, Executive Master of Health Services Administration, George Washington University.

Patient experience and satisfaction, however, may not have the emphasis they previously did prior to the pandemic. Patients and families will still expect a certain level of personalized care. However, visits with nurses may satisfy that need

and become more prevalent in our future, according to Steve Nadeau, former executive vice president, Gwinnett Medical Center, Lawrenceville, Ga.

Patient experience and satisfaction, however, may not have the emphasis they previously did prior to the pandemic. Patients and families will still expect a certain level of personalized care.

Changing Approaches to Preparedness

The COVID-19 situation will have lasting effects on hospitals’ and health systems’ disaster planning and preparedness strategies. “The infrastructure and processes that we created over the years, primarily to respond to natural disasters that have a more defined start and finish, need to be modified for pandemic situations,” says Phillip D. Robinson, FACHE, president, Lankenau Medical Center, Wynnewood, Pa.

In 2009, when planning for the possible swine flu outbreak, employers

urged staff who felt sick to stay home, entire schools were shut down and universities made plans to teach via online platforms. As time broke as that was at the time, “it would have been incomprehensible if local hospitals were to employ the same strategy,” Friedman says. During the swine flu outbreak, the question was asked: What do hospitals need to do to prepare for the next pandemic?

Foreseeing the future, Friedman proposed using alternative treatment sites for routine or nonpandemic-related care, freeing hospitals to treat the most critically ill patients only. He also suggested allowing nurses and paraprofessionals control over certain treatment areas.

We have now, during the current pandemic, experienced some of these changes. According to Fredrick “Skip” Burkle Jr., MD, senior fellow and scientist, Harvard Humanitarian Initiative, the healthcare field has learned two strategies from the 1918–1920 Spanish flu pandemic—social distancing and vaccines; however, Burkle cautions, “Social distancing will only work if it is done completely.”

Rise of Technology, Failure of the Medical Supply Chain

In an April 21, 2020, article in the *Prehospital and Disaster Medicine* journal addressing failures in the medical supply chain, Greg Burel, prior director of the Strategic National Stockpile for Assistant Secretary for Preparedness and Response, wrote: “There are limitations on all products ... The medical supply chain is very fragile ... There is never more than about 30 days of

A woman with dark hair, wearing a white t-shirt, is sitting at a table with a blue tablecloth. She is holding a blue laptop and looking at it with a thoughtful expression. On the table in front of her are a white mug, a plate with a sandwich, and a glass of orange juice. The background shows a window with white frames.

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Inspiring a Better Healthcare System

projected need for the entire market available ... There is no safety stock ... Coming out of this on the other side, we're going to have to really rethink the entire healthcare supply chain."

Throughout the COVID-19 crisis, of all the healthcare-related technologies, the EHR has made the tracking of patient demographics, trends and outcomes amazingly sophisticated, and "there is a gold mine of information available both to manage through the situation and in analyzing and learning from it after the fact," says Robinson. "Also, adding process engineers in the command centers, and with our key work teams, added a new level of sophistication for modeling surge plans, tracking utilization and clinical data, and allowing us to manage and adjust our plans, almost real time. This will continue in the future."

Protection of Workers' Mental and Physical Health

The mental and physical toll of this pandemic on the front-line workforce seems to be much greater, and may be much longer lasting, than as seen with even some of the major disasters of the past because it is nationwide and global in scope. A whole generation of healthcare workers will be permanently impacted by this experience, especially if it lingers over a year or two. Others may decide to leave the field as a result, Robinson suggests.

In addition, there most likely will be a continued demand for personal protective equipment in the workplace. The global lack of PPE during this pandemic and misunderstanding

about the importance of this issue is critical. Some institutions have been using PPE in ways inconsistent with standards of care, and patient treatment and provider protection is suffering as a result, according to Burkle. Whether it be in hospitals, or in the prehospital setting, there will be increased emphasis on thorough disinfection and airborne protection and use of PPE as a standard of care for all.

Rise of Telemedicine and Telehealth

The rapid growth in telemedicine begs the questions: How does this get paid for, and how do we deal with the interstate practice of medicine? George Washington University's Friedman believes these two questions will come into focus in the coming months.

Telemedicine will continue to expand and may become the norm for physician offices, especially for follow-up visits, suggests Nadeau. However, provider-initiated refusals (under medical direction and in conjunction with telemedicine) will see greater acceptance in prehospital care, according to Fifer.

Crisis Leadership

Healthcare administrators have reported that the lack of coordination at all levels caused delays and confusion during the early COVID-19 outbreak. James Phillips, MD, of the George Washington University School of Medicine and Health Sciences, states that at the highest levels, responding to this crisis cannot be about politics—it's about crisis leadership. The ability to communicate the issues at hand is critical.

"EQ is more important than IQ. Emotional intelligence is going to be one of the most important attributes for highly effective health sector leaders," says Friedman. Strong leadership, trusted communication based in science and coordination among all levels of government, public health and the entire healthcare continuum are—and will be—imperative.

Positive Futures?

The emergence of public health driving the medical response of our nation has arrived. The response of individual healthcare workers and the public has been positive. The Federal Emergency Management Agency has been granted authority to respond to pandemic events, which is new, and is also seen as a positive.

Global public health is also showing its value. And, in our future, wearable technology, combined with big data and analytics, will allow patients and clinicians to better manage chronic conditions, suggests Friedman. Adds Woodworth, "COVID-19, while tragic, may help us change ways we set standards and force needed changes in the way healthcare businesses are run." ▲

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John P. Duraes



Kim N. Hollon, FACHE

Improving Operations Through Efficiency

Multifront energy savings plan increases patient comfort, reduces costs.

Healthcare organizations today are seeking energy efficiency solutions to improve patient comfort, help them act as good environmental stewards and reduce costs. For a health system containing facilities that are up to 100 years old, such infrastructure upgrades are even more important. With that in mind, Signature Healthcare, Brockton, Mass., undertook several initiatives in 2018 to update old equipment and bring new efficiencies to the health system.

A Multipronged Plan

In 2018, Signature Healthcare's leadership was interested in pursuing energy efficiency solutions but had limited capital funding to address the needs of its facilities' outdated infrastructure. An opportunity came when a supplier partner approached Signature to participate in a guaranteed savings program to upgrade a 40-plus-year-old boiler and address several other energy efficiency needs.

Working with the supplier, Signature Healthcare conducted a 120-day assessment that identified several energy-efficiency improvements throughout the system, which encompasses seven locations, including the 124-year-old Brockton (Mass.) Hospital. The assessment also provided health

system leadership and the board with details about the age of the facilities' systems, including which ones were beyond life expectancy, were no longer supported by their manufacturers, or did not meet revised codes and standards. Using this information to form their decision-making process, system leadership approved entering into a 12-year contract with the supplier that focused on several key initiatives (see "Key Energy Improvements" on Page 35).

Significant Savings

Signature Healthcare's plan to reduce energy consumption and reduce overall costs has resulted in significant benefits to patients and staff. In addition to making patients more comfortable throughout the facilities, installation of newer, more reliable equipment will help eliminate vulnerabilities associated with equipment downtime or failures.

The improvements are projected to result in substantial financial savings as well. The health system estimates that the savings will pay for the \$9 million expense of installing the new equipment and systems. In addition, the supplier has guaranteed that savings. For example, if the savings are projected to be

\$400,000 per year but the actual savings are only \$380,000, the supplier will pay Signature Healthcare the difference. Overall, by May 2020, when the initiatives have been in place for a full year, the health system is projected to achieve more than \$380,000 in operational savings and more than \$470,000 in energy savings for the first year.

In addition to financial savings, the energy efficiency measures implemented will greatly reduce the health system's annual greenhouse gas emissions, with a projected 22% reduction of electricity use and natural gas reduction of 24%.

Lessons Learned

There have been several lessons learned by the health system's leadership:

Plan for the unexpected. When upgrading old equipment and infrastructure, organizations often discover other, related upgrades that need to be made. When Signature

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Healthcare updated its boilers, it discovered the electrical panel that supported its old boiler room would not support the newly improved one. The health system had to invest an additional \$80,000 to upgrade the electrical system.

Have a well-defined schedule.

Installing the new equipment took place during two phases and required a great deal of coordination. First, a temporary boiler system had to be connected to the building during the removal of the old plant and the construction of the new plant. Upon completion and testing of the new plant, the connection was made from the temporary boiler to the boiler's plant. With so many steps involved with both phases, the project schedule had to be well-defined. Among the

many schedule considerations, Signature's leadership had to take into account: the date for new equipment delivery; a date for temporary boiler connections; duration of the demolition of the original system; duration of the new system installation; and consideration for time of the year, with particular regard for weather conditions. Leaders should keep in mind that projects such as these could potentially affect an organization's fiscal budget for two years.

Involve end users in planning and design.

After the new equipment is installed, it is the mechanical engineers and other related staff who will be charged with operating the new equipment throughout the facility. It is crucial to seek input from the staff initially, during and

after any improvement projects. The end users can predict whether a certain design will help—or hinder—their work.

Finally, leaders must create a culture of communication and caring,

and build positive working relationships with the staff whose work is affected by major projects. Everyone feels better about their work when they have buy-in and understand the goals of new organizational initiatives. And that pride shows in the day-to-day operations of facilities old or new. ▲

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Key Energy Improvements

Working with a supplier through a guaranteed savings program, in 2018, Signature Healthcare embarked on several solutions to improve energy efficiency. The updates included:

Installation of five new 8.5-horsepower high-efficiency, high-pressure boilers that replaced boilers that were over 30 years old. The boilers are primarily used in the sterilization process of surgical and other instruments, and the new ones were relocated closer so that less steam was lost. The health system also installed three new low-pressure, 250-horsepower boilers, used for heating and hot water, which replaced older 500- and 300-horsepower boilers.

Automation of the health system's infrastructure.

The boilers were placed on electronic controls, which eliminated the need to have full-time standing engineers watching the boilers (licensed boiler operators mandated by state and county regulatory agencies to be present 24/7, 365 days per year). The health system estimates it will save close to

\$400,000 annually due to this automation and elimination of wages paid to full-time engineers.

Reduced water use, including installing flushometers in all urinals and toilets at the hospital and in all off-site locations.

Updated lighting system, including changing all lamps throughout the hospital and in the parking lots to LEDs from traditional incandescent lightbulbs. Newly installed lamps are warranted for up to 10 years, resulting in energy and cost savings on labor, as the bulbs will not have to be changed as frequently.

Upgraded HVAC system, including improved temperature and humidity controls in operating rooms.

Installation of a cogeneration unit in the hospital. This type of generator runs on natural gas, which is clean burning. It generates electricity for the building and produces hot water, which helps reduce wear and tear on the boilers.



Paul H. Keckley, PhD

COVID-19 Reveals Silver Linings

Hospital policies and procedures will improve in the wake of the new coronavirus.

The long-term impact of the coronavirus pandemic on the U.S. economy and the health delivery system is still being assessed. What's clear is that it has thrust hospitals to the forefront of public consciousness.

As the surge progressed, attention focused on the adequacy of beds and supplies and the heroism of front-line caregivers. Administrators transitioned to crisis mode: The immediate availability of N95 masks, ventilators and ICU beds displaced all other concerns.

outbreaks at home and abroad under the umbrella of the Centers for Disease Control and Prevention.

Infectious diseases and social determinants of health that heighten a community's susceptibility to infection are not a primary focus for most hospitals, medical practitioners and insurers. Epidemiology and disease prevention are typically out of scope until they require treatment. Often, that's too late.

The COVID-19 pandemic was predictable: it's the fifth global coronavirus pandemic in 20 years. Warnings were sounded as early as April 2019. However, CDC guidance about the COVID-19 pandemic was slow, leaving some hospitals and physicians ill-equipped to respond to the eventual deluge of patients.

Ultimately, this inadequate level of preparation will bolster public awareness about disease surveillance, investments in public health programs will grow, and closer collaboration between public health agencies and local hospitals will be a top priority in every community.

Accelerating Technology-Enabled Virtual Care

One of the key provisions of the Coronavirus Aid, Relief and

Economic Security Act is an emphasis on and increase in the use of telehealth in patient care. Studies show that virtual visits could effectively replace office visits, but physicians pushed back citing three concerns: 1. the potential for breaches of patient privacy, 2. the inadequacy of virtual interactions in capturing vital patient information (e.g., signs, symptoms, risk factors, comorbidities) and 3. low reimbursement by private insurers. A 2019 survey of physicians conducted by a telehealth company reports physicians' willingness to use telemedicine increased from 57% to 69% between 2015 and 2018, but only 22% were actual users. Physician reluctance was the major deterrent to wider use of telehealth before the pandemic.

Public acceptance of telehealth is not an issue. A study published in *JAMA* in 2018 found that from 2005 to 2017, there were 383,565 telemedicine visits by 217,851 patients growing at a rate of 52% annually. The mean age of users was 38.3 years; 63% were female, 83.3% resided in urban areas and telemental health (53%) or primary care telemedicine (39%) were the major reasons for use.

Insurers support increased use of telemedicine. Legislators in 32 states have passed parity laws to advance its use. Thus, barriers to telehealth were lowering as the pandemic hit the U.S. health system. The CARES Act pushed it into mainstream delivery by requiring insurers to cover it and waiving physician culpability for HIPAA violations. As social distancing was implemented, clinicians used telemedicine out of necessity.

20% OF FRONT-LINE CAREGIVERS treating COVID-19 patients got infected.

It's clear the pandemic has had a profound negative impact on hospitals. Operating margins have disappeared. Debt covenants are being renegotiated. Uncompensated care is up, and workforces are stretched thin. However, there are silver linings to be found for hospitals from the COVID-19 pandemic.

Elevated Strategic Imperatives: Public Health and Emergency Preparedness

The U.S. public health system is a network of federal, state and local agencies that monitor disease

Consequently, the use of telemedicine in patient care will accelerate as physician resistance shrinks, insurer coverage increases and consumers adopt it more widely.

Rationalizing Acute Resources

The biggest and potentially most consequential result of the coronavirus is likely a fresh discussion about the role, scope and optimal arrangement of hospital services in our system. It's a delicate but inevitable deliberation we're destined to have.

Today, there are 6,142 hospitals in the United States: 5,197 (85%) of these are community hospitals operated as private for-profit (2,937), investor-owned (1,295) or public hospitals (965). Some are big; most are small. Some are very profitable; many are not. Some offer a full range of preventive, chronic, acute and long-term care services; most don't. It's a highly regulated sector where local competition is intense and operating margins are shrinking.

The COVID-19 pandemic represents the single biggest threat to the viability of hospitals in a generation. "We believe the pandemic will result in sizeable increases in operating costs, particularly for labor and supplies, reduced volume and revenues related to elective and nonessential healthcare needs, reliance on working capital lines of credit, and material declines in unrestricted reserves and nonoperating revenue as the investment markets weaken," S&P Global Ratings states in a March 25 report.

Every hospital was required to delay or cancel elective surgical and diagnostic procedures and nonemergency office visits to prepare for the

coronavirus. That meant 50% to 80% of a hospital's revenues disappeared for two months in most communities. Treatment of COVID-19 patients resulted in as many as 20% of front-line caregivers being infected. Furthermore, uncompensated care skyrocketed as the ranks of the uninsured increased by 15 million.

What's ahead for hospitals? As a direct result of the pandemic and its aftereffect on the U.S. economy, hospital consolidation will accelerate, and approval by state and federal regulators will weigh public health preparedness more heavily. In all likelihood, that means hospitals will consolidate operations, reallocate capital to preventive and primary care, and rationalize investments in traditional acute programs.

Therein lies the third silver lining: The pandemic will require hospitals to rationalize traditional acute care programs to fund investments in primary care and public health services.

As hospital leaders settle into the post-COVID-19 new normal, day-to-day operations will be modified based on lessons learned. All will refresh policies and procedures for infection controls, procurement, ED triage, formulary design, surge staffing, crisis communications, patient transportation, security and much more.

How fast and in what forms these changes occur is hard to predict, but all are inevitable. What's also inevitable are the silver linings that are likely results of the coronavirus. ▲

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David Lapin

Leading by Greatness During Crisis

Humility, vulnerability, generosity are keys to trust and career building.

Leading by greatness is the capacity to inspire your teams to extraordinary performance by bringing the fullness of who you are into the way you show up and lead each day. In times of crisis, this capacity is more important than ever.

We are conditioned to behave professionally at work. We bring our mental capacities, our skills and our training to work, but we tend to mask our deeper, authentic beings. And yet, our authentic selves are the only vehicle we have by which to inspire the trust of others. By hiding our deeper selves, we inhibit trust-building and inspiration.

In times of crisis more than ever your people want to know how you are feeling, not only what you are thinking. When we wear our professional “mask,” people wonder what lies beneath it. Without having some level of insight into your feelings and beliefs, it is hard for them to trust you.

In the Lead by Greatness leadership philosophy, there are three key levers of trust: humility, vulnerability and generosity.

Humility

Humility is knowing that as unique, talented and qualified as you are, you are also part of something much bigger than you. But it is more than your

being *part* of something bigger than you. Humility is believing that you are here to *serve* something bigger than you and people other than you.

Understanding that we are all here to serve, although we are each free to choose who or what we serve and how we wish to serve them, is the foundation of leadership humility.

Leaders in healthcare are particularly fortunate in that their vocation is obvious and ever-present. There are, however, two risks to a healthcare leader’s humility. First, there is the risk of hubris resulting from the loftiness of healthcare’s higher purpose. Professionals can easily forget that the individual sitting in front of you is the individual you are here to serve at that moment, no matter who he or she is. Leaders need to inspire professionals with this ethos. Second, as healthcare has become more focused on efficiency-driven processes, it is too easy to lose focus of the human suffering and needs of the person in front of you. Policymakers might treat healthcare as a set of data points. For the professional, though, healthcare is about real humans, one as important as the next; a single life is as important as 1,000 lives. Patients feel your energy and know the inner place from which you are approaching them. As such, your care is as important for their health as is your expertise.

Vulnerability

Vulnerability is not the indiscriminate and uncontained bearing of your soul or revelation of your deepest feelings. Leadership vulnerability is making sure that the image you project to others is aligned with your identity. Vulnerability is knowing what your true value-drivers are (the values that are core to who you are as a human being) and allowing the people around you to experience them. It requires that you draw on your value-drivers when you make decisions, have conversations and act.

It is natural that healthcare professionals protect themselves from emotional entanglement with patients by adopting a professional and somewhat impersonal veneer. It is valuable in building trust to open yourself a little and share some of your own vulnerabilities and those of the healthcare system. Show the way to your teams by starting to open up to them in ways that are authentic and vulnerable.

Generosity

Generosity is not unconditional giving; such giving is not sustainable. Leadership generosity means investing your time, attention and resources into people who matter to you. Investing in them rather than donating to them means you have expectations of some form of return. It is generous to let people know why you are investing in them and what your expectations are. This way they know what to do to

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The barrier to leading with heroic greatness is the impact of fear on our limbic nervous systems, triggering us into defensive emotions and responses. When we react defensively, we tend to focus on our own survival and that of our immediate family to the exclusion of any notion of service to others. During crisis times, it is natural to default into survival mode, making defensive decisions that may serve us in the short term but could cause destructive harm in the longer term. This is more so for leaders in healthcare who often work under conditions of emergency and stress and can easily be triggered into impatience as they focus on their own


most immediate pressures. Being generous with your time and attention is difficult to achieve when a professional is being measured primarily by efficiency. A course of action is to help the people in your teams balance the system's needs for efficiency with the patient's need for care and attention.

In times of emergency, we naturally first respond to the immediacy of the crisis; however, as soon as possible thereafter, it is important to shift gears from a defensive, fear-driven stance to one of heroic greatness. This shift requires first and foremost that we reconnect with the people who matter to us both at work and at home and who may not have felt our presence while we were focused on our response

to the crisis at hand. Our reconnection must go beyond the transactional. We need to find ways to connect with people on a deeper, existential level. They need that from us, and as leaders, we need it too.

Reconnect

Through the crisis we may have been doing a great deal of communicating with people using various technology platforms. But communicating does not necessarily mean *connecting*. We connect with others when making them the center of our attention during our interaction. It is hard for people to feel this over the phone or even a video conference. It is also difficult to make the other person the center of our attention when we are in crisis mode and worried about survival.



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As with all trust-building activities, connection should contain all three ingredients of trust: humility, vulnerability and generosity. When reconnecting with the people in your life who matter, make sure you are not multitasking and that your attention is not split. Doing other things or thinking about other things while talking to someone does not demonstrate humility and service of the other. Do your best to focus all your attention on the person with whom you are engaging. Giving another your undivided attention is one of the most generous things you can do for them. Inquire about them personally, not just professionally, and expose some of your own vulnerability by sharing with them what you are struggling with and what you find particularly

challenging. In addition, demonstrate genuine interest in how they are managing and in how their families are doing. Ask them what they are struggling with the most. When they share this with you, don't feel obliged to offer advice; giving them your attention is what they will value.

This approach of connecting with people using humility, vulnerability and generosity is crucial not only in times of crisis. This approach is also a key component in building your career. Professional competence is not the only factor that drives career advancement. Being trusted by your peers and a sought-after resource of wisdom, guidance and support is important for the development of a career in any organization. In healthcare, these

factors weigh even more heavily than in other industries because leaders in healthcare depend so much more on the trust they inspire in the people they lead, the stakeholders they engage and the communities they serve.

Connection is the key to trust, and trust is the vehicle by which to inspire extraordinary acts of both caring and performance. ▲

David Lapin is CEO of Lapin International Inc., a consulting and coaching firm that helps individuals and organizations achieve strategic clarity and leadership alignment. Lapin has significant experience in healthcare. Please follow him on LinkedIn (linkedin.com/in/davidlapin) or Twitter (@DavidLapin).

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COVID-19 and Executive Succession Management

The pandemic has exposed the need to improve planning for executive turnover.

The COVID-19 pandemic has made executive succession planning even more critical for the board, considering that only 45% have a plan in place for CEO (and other senior executive) succession, according to The Governance Institute's 2019 Biennial Survey of Hospitals and Healthcare Systems. This was true, even though 80% of survey respondents agreed that "succession planning for the CEO and other senior executives is a critical board responsibility."

Although some CEOs may defer their expected retirement, how many will instead lead their organizations through the first wave of the pandemic but then decide they don't have the stamina needed to lead through the next wave? Faced with daunting financial pressures related to the pandemic, will talented executives decide to leave the field of healthcare management rather than face endless rounds of layoffs, furloughs and cost-cutting?

The following six practical tips can help organizations immediately take necessary steps toward ensuring effective leadership succession management.

Establish succession planning as one of this year's board priorities.

Despite the many changes COVID-19 has wrought, every organization should include the creation or update of a leadership succession plan as a key board goal for the next six months. The board chair or vice chair should oversee this effort in collaboration with the CEO.

The risks of not having succession or contingency plans in place are far worse than the anxiety and effort involved in developing them.

Incorporate succession planning objectives into this year's updated CEO performance expectations.

Many (if not most) of the performance expectations that the board and CEO agreed on at the start of fiscal year 2020 will need to be adjusted to reflect the impact from COVID-19. The creation and maintenance of robust CEO succession and leadership development plans should be incorporated into this year's expectations for the CEO, for which he or she will be held accountable. Even if the CEO has no plans for retirement or departure, having these plans in place benefits

the CEO in leaving behind a legacy of having built a strong, successful team and an organization that did not miss a step upon his or her departure, no matter the circumstances.

Create a robust CEO succession plan. With the many disruptions associated with COVID-19, it is not sufficient for the CEO succession plan to focus narrowly on simply naming a designated successor or agreeing on which executive search firm to hire to identify external candidates. The CEO, working collaboratively with the chair and executive committee, should develop a robust plan that includes: competencies and attributes needed in a future CEO to accomplish the organization's strategic vision and plan; a succession timetable; approaches to retaining senior leaders; potential future role(s) for the departing CEO, if any; a transition plan; retention planning for key executives; a communications plan; a rationale for and/or an approach to using an external search firm (if any); and a preferred timetable for a planned retirement or departure.

Confirm that contingency plans are up to date. Amid this pandemic, an unexpected CEO departure would be particularly disruptive to an organization at a time when strong leadership

is most needed. It is essential that an up-to-date emergency succession plan is in place that identifies who would serve as interim CEO. Preferably, the interim CEO would be a competent current senior leader who knows the organization, its culture and its priorities. Alternatively, the board should have a firm grasp on what external organizations and resources can be used to fill the interim role quickly.

Develop the next generation of leaders. Developing future leaders should be considered a necessity that is integral to an organization's operations. This pandemic has highlighted many of our health system's vulnerabilities. Somewhat less visible may be how effectively organizations have developed their next generation of leaders. Thriving hospitals and health systems already know who among their millennial and Generation X managers are in the leadership pipeline. These institutions conduct robust annual talent reviews of mid- and senior-level administrative and physician leaders, identify who is prepared or might be cultivated to replace each current senior leader, and individualize leadership development plans.

High-performing boards endorse these leadership development plans and create opportunities for directors and trustees to interact with up-and-coming potential C-suite leaders through informal events and formal processes, such as presentations at board retreats or meetings, or by serving as staff for board committees and task forces.

Ensure a successful and smooth transition to the next CEO. Now more than ever, a new CEO needs to

hit the ground running. He or she, working in tandem with the board, should quickly get up to speed on the organization's strategic direction, short-term priorities and culture. The new CEO should work with the board to help establish strategically or politically important connections within the organization and in the local and regional communities. The CEO should also expect the board to express clear year-one CEO performance objectives and expectations for which the new CEO will be held accountable, recognizing that if COVID-19 persists or is supplanted by a similarly disruptive event, both the board and the CEO must be open to modifying these objectives.

Even thinking about replacing senior leaders during this unprecedented crisis may seem overwhelming. A current leader's strength and stability may lull leadership into a false sense of security. It can be tempting to hope for continued stable leadership until the pandemic has passed; however, hope is not a strategy. The risks of not having succession or contingency plans in place are far worse than the anxiety and effort involved in developing them. Taking an intentional approach to succession planning will pay long-term dividends for achieving the organization's mission without interruption—regardless of future pandemics, uncertainties and disruptions. ▲



Jennings

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Todd P. Sklamberg

Leading in Crisis

A CEO's firsthand account of the Las Vegas shooting, response to COVID-19.

No U.S. hospital in recent history has cared for more gunshot victims at one time than Las Vegas' Sunrise Hospital & Medical Center on the night of Oct. 1, 2017. For its physicians, clinical and nonclinical team members, first responders, and the entire Las Vegas community, the tragedy that night was beyond all comprehension. A culture of preparedness would serve the organization well, one it draws upon today during the global COVID-19 pandemic.

Sunrise Hospital & Medical Center is the largest acute care facility in Nevada. A 762-bed adult and children's hospital, it is a regional center for tertiary care and features a Level II trauma center. It is the closest hospital to the Las Vegas Strip.

On Oct. 1, 2017, Sunrise Hospital's senior leaders and staff received a page shortly after 10 p.m. during the Las Vegas Route 91 Harvest festival advising of a mass casualty. The number of victims and extent of injuries from the incident at Mandalay Bay Resort and Casino, just 4.8 miles from Sunrise Hospital, were unknown at the time. What followed tested the mettle of the Sunrise Hospital team, but they were prepared to rise to the occasion.

Ambulances, cars, pickup trucks and taxis flooded the Sunrise Hospital

ambulance bay. Over 100 physicians and more than 200 nurses responded to assist over 240 patients arriving at Sunrise Hospital for care in a span of two hours. Over 80 surgeries were performed during the first five days (58 of those in the first 24 hours), 516 blood products were administered and 50 crash carts were deployed within one hour.

How does Sunrise Hospital bring order and stability in times of chaos and uncertainty? Strength, perseverance and hope. At every turn during its response, Sunrise Hospital staff displays these traits, benefiting its teams, patients and their families.

Communicating in a Sea of Fear and Uncertainty

Sunrise Hospital prioritized the flow of structured communication to families from the onset of the crisis. CEOs, physicians and nurses are empathetic leaders who are well-trained to share the most difficult of messages with families. The majority of the organization's everyday family interactions are tight and contained. There are certainties: We know the identity of the patient and whether the EHR is accessible. Hospital and health system staff members are prepared with appropriate responses to

family in the event of an escalating situation, yet 99.99% of those fall into the category of certainty.

Imagine, however, the uncertainty the shooting victims' families experienced when they arrived at Sunrise Hospital desperately searching for answers, with no idea if their loved ones were at Sunrise Hospital or elsewhere in Las Vegas. Were their loved ones even still alive? Compounding the situation was the fact that many were unfamiliar with the city, its healthcare system or Sunrise Hospital.

To alleviate this uncertainty, the hospital organized ongoing updates for the families every 30 minutes, starting at midnight on Oct. 2. It shared information from its CEO and attempted to give families some sense of hope that their loved ones were alive and would be provided the best medical and traumatic care available.

Initially, 92 of the victims had no identification because clutches, purses and wallets were displaced during the attack. Our Incident Command Center team found answers using an old-fashioned approach: comparing families' descriptions and photos to our team's own visual descriptors. This process accelerated patient identification, with tattoos, piercings and even boots becoming definitive identifiers.

This column is made possible in part by Optum.



The Right Team at the Right Time at the Right Place

There are similarities between Sunrise Hospital's response to Oct. 1 and COVID-19. Oct. 1 was a single point in time. One page and an hour later, 250 patients flooded the ED with an immediate crisis managed over an extended period. The global pandemic provided advanced notice of what we might be facing and the ability to plan for various scenarios spanning months.

Communicating and connecting with the Sunrise Hospital team throughout both events has been of paramount importance. Expressing gratitude to our team for being there at the right time is always mission critical. As the pandemic continues, we see a stress on the global supply chain, so ensuring our team has a safe and healthy work environment with appropriate personal protective equipment is a top priority.

Sunrise Hospital had the right team at the right time at the right place for Oct. 1. It all started with the hospital initially establishing a triage process in the ED that was similar to combat triage, enabling the hospital to provide immediate, lifesaving care for an unprecedented patient volume in the following ways:

- A physician experienced in tactical situations made an early decision to designate areas in the ED for specific care.
- ED and trauma physician leaders developed a strategy for stabilizing patients in the ED before immediately transferring them to other areas in the hospital per primary injury category. The hospital dispatched subspecialists to

units housing patients requiring their expertise.

- ED and trauma physicians took the lead on the immediate triage of victims, directing them to appropriate areas.
- A trauma physician took the lead on surgical triage and directed surgical strategy.
- ED nurses rapidly reprioritized patients and initially engaged in the resuscitation of multiple patients until additional staff arrived.
- Leaders took a pause in care to organize a system response, a critical factor in maintaining control during the crisis.
- Paramedics and flight crews on-site supported Sunrise Hospital staff. The Sunrise care team used intraosseous infusion to more effectively and efficiently place IVs.
- Clinical staff self-dispatched to support the anticipated need at Sunrise Hospital and upon arrival, took on the role or task needed at that time.
- Pulmonary and critical care staff were available and engaged in ongoing care needs to leverage trauma team capabilities.

Sunrise Hospital also demonstrated many nonclinical strengths throughout the crisis:

- An experienced hospital team led the Incident Command Structure.
- Early in the crisis, the hospital established a family staging area to separate families from the clinical unit, allowing staff to ensure care for a large volume of patients.
- Ongoing updates at regular times helped manage families' anxiety and expectations.

- CEO-led updates assured families that the top leader was addressing their concerns.

From the New York City Emergency Preparedness team to local EMS, the Federal Emergency Management Agency and multiple organizations, we have shared our crisis response best practices with the hope of helping others be crisis-ready. Sunrise Hospital recently opened a new, state-of-the-art tower, including a new, expanded trauma and adult ED and ambulance bay designed with many of the lessons learned from Oct. 1.

Today, we are seeing the same, unparalleled perseverance of our entire organization as on Oct. 1. The hope for our team, patients, community and our nation still runs deep in Sunrise Hospital's veins. After a month or two following Oct. 1, the vast majority of our patients were discharged and the healing process began for our patients, staff and community. In contrast, we must prepare for the pandemic as an ultramarathon. We will be working with our patients and the clinical need for months, if not longer. The runway for recovery will be months or years for our nation and Las Vegas.

As of June 5, we discharged our 134th COVID-19 patient with more to come. Like Oct. 1, strength, perseverance and hope have served our team well. We remain forever #SunriseStrong. ▲

Todd P. Sklamberg is CEO, Sunrise Hospital & Medical Center and Sunrise Children's Hospital, Las Vegas, and an ACHE Member (Todd.Sklamberg@hcahealthcare.com).

ACHE MEMBER UPDATE

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 2019–2020 committee year, the Ethics Committee considered seven grievances concerning ACHE members. Of these, three cases were dismissed, one case resulted in a

censure, one case resulted in an expulsion and two cases continue, pending court action.

The Ethics Committee is also 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

revisions and topics for new statements.

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

Wyoming Health System Receives 2019 AHA Rural Hospital Leadership Award

Cody (Wyo.) Regional Health, led by ACHE Member **Douglas A. McMillan**, CEO, was named the recipient of the 2019 American Hospital Association 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.

in Community Service. Sponsored by Baxter International Foundation, the American Hospital Association and 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 Exceptional Workplace Award

Five member-led organizations received the 2020 Gallup Exceptional Workplace Award, which recognizes employee engagement. They are:

- Hendrick Health System, Abilene, Texas, led by **Brad D. Holland, FACHE**, president/CEO
- Mary Lanning Healthcare, Hastings, Neb., led by **Eric A. Barber**, president/CEO
- Self Regional Healthcare, Greenwood, S.C., led by **James A. Pfeiffer, FACHE**, president/CEO

They were among 38 organizations in a variety of industries that received the award.

Ohio Health System Recognized for Community Service Excellence

ProMedica, Toledo, Ohio, led by **Randall D. Oostra, DM, FACHE**, president/CEO, received the 2019 Foster G. McGaw Prize for Excellence

- Adena Health System, Chillicothe, Ohio, led by **Jeffrey J. Graham**, president/CEO
- Hawai’i Pacific Health, Honolulu, led by **Raymond P. Vara Jr.**, president/CEO

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This column is made possible in part by Change Healthcare.



COVID-19 MEMBER NEWS

As the COVID-19 pandemic continues to impact our communities, ACHE has been regularly sharing news about our members on the front lines fighting the novel coronavirus and the disease caused by it, COVID-19. We would like to thank them and all healthcare professionals who are serving and leading during the pandemic.



Henry

The experience of caring for COVID-19 patients will have a lasting impact on Lake Regional Health System, Osage Beach, Mo., and on healthcare in general, according to **Dane W. Henry, FACHE**, CEO. The hospital is using data and experience with its supply chain to plan now for the fall and beyond, he says.



Dawson

Martha A. Dawson, DNP, RN, FACHE, president, National Black Nurses Association, and associate professor, nursing, University of Alabama at Birmingham School of Nursing, is sharing innovations that can help address the disproportionate impact of COVID-19 on minority communities.



Tam

Community partnerships are more important than ever in fighting the pandemic, according to **David A. Tam, MD, FACHE**, president and CEO, Beebe Healthcare,

Lewes, Del. He says his organization would not have been able to accomplish a multiday event that offered expanded COVID-19 testing at four sites without the help of community and government partners.

ACHE is grateful to these members and so many others for the commendable battle they have waged against the pandemic. To read more stories, visit “COVID-19 Member News” at [HealthcareExecutive.org/WebExtras](https://www.healthcareexecutive.org/WebExtras).

In Memoriam

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

Steven Badger, FACHE
Centerton, Ark.

Roman Corral
Los Angeles

Sister M. Therese Gottschalk, FACHE
Tulsa, Okla.

Donald L. Jernigan, PhD
Longwood, Fla.

Benjamin M. McKibbens, FACHE
Mobile, Ala.

Wade Mountz, FACHE
Louisville, Ky.

Robert W. Oldfield
Richmond, Va.

Kelly D. Pottorff
St. Francis, Kan.

A. Rodney Thorfinnson, FACHE
Owen Sound, Ontario

ACHE STAFF UPDATE

ACHE Announces Staff Retirement

Following is an ACHE staff member retirement:



Hahn

Cynthia A. “Sinde” Hahn, FACHE, CAE, to retirement from senior vice president, Department of Member Services. Sinde joined ACHE in 1987 as assistant director of programmed activities. After leaving

ACHE in 1991, she returned in 1992 as a consultant and was promoted to associate director, Membership. In 1995, she was again promoted to vice president, Membership, and in 2013 to senior vice president. During her tenure with ACHE, she has contributed to the association in many ways, including more than doubling the number of members. We would like to thank Sinde for her many years of service to the healthcare field.

Comparing Salaries of Women and Men Healthcare Executives

Results provided by ACHE's Department of Member Services, Research.

In late 2018, ACHE conducted the sixth in a series of studies comparing career attainments of women and men healthcare executives. ACHE has conducted these studies every five to six years since 1990. In all, 5,138 men and women members of ACHE received the 2018 study survey, although only about half, 2,566, received questions about their compensation in 2017. Of those, 769 responded for an overall response rate of 30%.

Having attained approximately equal levels of education and experience, women healthcare executives in the 2017 study on average earned about \$155,200, and men earned on average about \$183,700. Thus, women earned 16% less overall than men. This represents an improvement from 2012 when the gap was 20% but is similar to the findings from some of the earlier surveys (See Table 1).

Table 2 shows median 2017 salaries by position level for men and women executives in full-time positions in the study. Men at each level outearned their women counterparts, except in the category of department head and staff. For the first time since these studies began, the median salary for women in department head and staff roles drew even with that of men. The relatively lower earnings of women CEOs compared with women in other senior positions may be due to the fact that women CEOs in the study tended to work in smaller organizations than women in other senior positions.

One possible explanation for the lower median salaries for women executives is they are more likely than their male counterparts to have interrupted their careers to care for children or other reasons; however,

Table 1: Median salaries of samples of men and women healthcare executives, 1989–2017

Year	Median Salary	
	Men	Women
1989	\$69,400	\$57,200
1994	\$85,900	\$71,700
1999	\$104,300	\$84,900
2005	\$131,000	\$107,800
2011	\$166,900	\$134,100
2017	\$183,700	\$155,200

Table 2: Median 2017 salaries of samples of men and women healthcare executives by position

Position	Median Salary	
	Men	Women
CEO	\$250,400	\$176,300
(n) ¹	(50)	(50)
COO/Associate Administrator	\$214,600	\$196,100
(n) ¹	(49)	(38)
Other C-Suite, Senior Vice President	\$237,000	\$224,300
(n) ¹	(50)	(48)
Vice President	\$209,600	\$176,800
(n) ¹	(69)	(66)
Department Head, Staff	\$134,800	\$137,300
(n) ¹	(114)	(161)

¹ Sample size

the data show that women answering the survey who left the workforce for three months or more did not incur salary penalties compared with women who did not interrupt their careers. In fact, women with career interruptions as a group earned a median salary of \$167,900 in 2017, slightly more than the \$153,500 median salary for those who did not experience breaks in their careers.

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

The Fund for Healthcare Leadership would like to thank these outstanding individuals and organizations that have continued to support ACE's mission year after year. This list highlights lifetime giving amounts and recognition levels of this prestigious group.

This list reflects lifetime gifts received as of Dec. 31, 2019.

Visionary: \$100,000 and up

Toshiba America Medical Systems, Inc.

Innovator: \$50,000–\$99,999

Catholic Health Initiatives (Kevin E. Lofton, FACHE)
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Leader: \$25,000–\$49,999

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Baylor Scott and White Health
Deborah J. Bowen, FACHE, CAE, and R. Norris Orms, FACHE, CAE
BrightStar Care (John Botsko Jr., FACHE)
Carolinas HealthCare System
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Columbus Regional Healthcare System
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Christine Candio, RN, FACHE, and Vincent Candio
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A. David Jimenez, LFACTHE

Sara M. Johnson, FACHE
Alan N. King
Michael A. King, LFACTHE, and Catherine A. King
James Y. Lee, FACHE, and Mamie I. Lee
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Christine C. Winn, FACHE
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When you contribute to the Fund, you are investing in the future of our profession. Your support ensures the field is rich with leaders who have the tools and knowledge to provide the best in healthcare delivery. Make your 2020 contribution today.

Visit ache.org/Fund or call (312) 424-9305 to learn more.



Bledsoe



Briner



Gordon



Miller



Schnabel



Self

Bernie Albertini, RPh, FACHE, to COO, East Ohio Hospital's recently acquired Martins Ferry property, from COO, Canyon Vista Medical Center, Sierra Vista, Ariz.

HMC Kevin P. Amick to director of Butler (Pa.) VA Health Care System from associate medical center director, Durham (N.C.) VA Health Care System.

LCDR Manuel H. Beltran, FACHE, to medical plans officer, United States Pacific Fleet, Pearl Harbor, Hawaii, from medical readiness analyst, The Joint Chiefs of Staff, The Pentagon, Washington, D.C.

Dana Bledsoe, DHA, FACHE, to the Strategic Advisory Board of Andor Health, Orlando, Fla. Bledsoe is the former president of Nemours Children's Hospital and enterprise vice president, Nemours Children's Health System, Orlando, Fla.

Robert S. Briner, FACHE, to director, LifeGift, Houston, from CEO, Sweeny (Texas) Hospital District.

Mark A. Caron, FACHE, to retirement from CEO, Geneia, Harrisburg,

Pa. We would like to thank Mark for his many years of service to the healthcare field.

Reba Celsor to CEO, LifePoint Health's Spring View Hospital, Lebanon, Ky., from CEO, West Tennessee Healthcare Dyersburg Hospital.

Stephan Davis, DNP, FACHE, to assistant professor/director, Master of Health Administration program, University of North Texas Health Science Center, from clinical assistant professor, Georgia State University, Atlanta.

Kathy Donovan, RN, NE-BC, to CEO, Children's Hospital of Michigan, Detroit, from COO and CNO, SMM Health Cardinal Glennon Children's Hospital, St. Louis.

Mark Doyle to president and CEO, Holy Cross Hospital, Fort Lauderdale, Fla., from CEO, Memorial Hospital Pembroke, Pembroke Pines, Fla.

Aphreikah Duhaney-West, FACHE, to COO, Shreveport hospital operations, Ochsner LSU Health Shreveport (La.)—Academic Medical Center, from CEO, Teche Regional Medical

Center (now Ochsner St. Mary), Morgan City, La.

Claudia Eisenmann, FACHE, to CEO of Methodist Health Union County, Morganfield, Ky. She will continue in her current role as president/CEO, Gibson General Hospital, Princeton, Ind.

Eric Evans to CEO, Corpus Christi (Texas) Medical Center, from CEO, HCA Houston Healthcare Tomball.

Jared Giles, FACHE, to CEO, Southwest Healthcare System, Murrieta, Calif., from COO.

Andrew Goldfrach, FACHE, to COO, Arrowhead Regional Medical Center, Colton, Calif., from CEO, University Hospitals Avon (Ohio) Rehabilitation Hospital.

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This column is made possible in part by Cerner.





American College of
Healthcare Executives
for leaders who care®

Official Notice for the 2020–2021 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 ACE'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 an electronic letter of intent to elections@ache.org by Aug. 21, 2020. If you submit your letter of intent and you haven't received confirmation by Aug. 28, 2020, 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 2021 Council of Regents meeting during ACE'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 2020–2021 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:

Alabama
Alaska
Colorado
Delaware
Hawaii/Pacific
Idaho

Kansas
Louisiana
Maine
Massachusetts
Mississippi
New Hampshire

Oklahoma
Oregon
Rhode Island
Texas—Northern
Utah
Wisconsin

Mark M. Gordon, FACHE, to president, Alamance Regional Medical Center, Burlington, N.C., and senior vice president, Cone Health, Greensboro, N.C., from CEO, Bon Secours Memorial Regional Medical Center, Mechanicsville, Va.

Dustin A. Greene, FACHE, to CEO, TriStar Skyline Medical Center, Nashville, Tenn., from CEO, TriStar Horizon Medical Center, Dickson, Tenn.

Rod Harkload, RN, to CEO, LifePoint Health's Frye Regional Medical Center, a Duke LifePoint Hospital, Hickory, N.C., from CEO, Haywood Regional Medical Center, Clyde, N.C., also a Duke LifePoint facility.

William Holubek, MD, to CMO, University Hospital, Newark, N.J., from vice president of medical affairs and CMO, Wellstar Atlanta Medical Center.

William Scott Hurst, FACHE, to CEO/president, Patient Physician Network, Plano, Texas, from executive director, Texas Operations, naviHealth, Nashville, Tenn.

Robert Iannaccone to executive vice president, University Hospital, Newark, N.J., from CEO, Saint Michael's Medical Center, a member of the Prime Healthcare System, Newark.

David Kent to CEO, Piedmont Newton Hospital, Covington, Ga., from senior vice president, business development, Cancer Treatment Centers of America, Boca Raton, Fla.

Min Lee to vice president, operations, Reading Hospital, West Reading, Pa., from vice president of operations, Emory Healthcare, Emory University Hospital Midtown, Atlanta.

Chad T. Lefteris, FACHE, to CEO, UCI Health, Orange, Calif., from COO.

Steven G. Littleson, FACHE, to president, Central Maine Medical Center, Lewiston, Maine, from chief integration and operating officer, Lancaster (Pa.) General Health.

Patricia Luker to interim CEO, Perry Memorial Hospital, Princeton, Ill., from retirement.

James McHugh, FACHE, to managing director, Impact Advisors, Naperville, Ill., from partner, Guidehouse, Chicago.

Kimberly J. Miller, FACHE, to president, Baptist Health Western Region, Fort Smith, Ark., from president/CEO, Beaver Dam (Wis.) Community Hospitals.

Brad Neet, FACHE, to group vice president, Southern California, Universal Health Services' Acute Care Division, Murrieta, Calif., from CEO, Southwest Healthcare System, Murrieta, Calif.

Peter Powers, FACHE, to CEO, Memorial Regional Hospital, Hollywood, Fla., from CEO, St. Anthony Hospital, Lakewood, Colo.

Zeff Ross, FACHE, to retirement from executive vice president,

Memorial Healthcare System, and CEO, Memorial Regional Hospital, both in Hollywood, Fla. We would like to thank Zeff for his many years of service to the healthcare field.

Annette D. Schnabel, DPT, FACHE, to president, Parkland Health Center, Farmington, Mo., from president/CEO, Perry Memorial Hospital, Princeton, Ill.

Craig Self, FACHE, to chief strategy/business development officer, Roper St. Francis Healthcare, Charleston, S.C., from chief strategy/business development officer, Premier Health, Dayton, Ohio.

Scott Smith to CEO, LifePoint Health's National Park Medical Center, Hot Springs, Ark., from CEO, Western Plains Medical Complex, Dodge City, Kan.

Marcela Sweeney to hospital assistant CNO, North Shore Medical Center, Miami, from assistant CNO, Coral Gables (Fla.) Hospital.

Lt Col Edward P. Syron, PhD, FACHE, to retirement from chief, Primary Care Services, Dayton (Ohio) VA Medical Center. He will continue as adjunct associate professor and graduate school course director, Wright State University Boonschoft School of Medicine, Dayton, Ohio.

Want to submit? Send your "On the Move" submission to he-editor@ache.org by Aug. 3 to be considered for the November/December issue.



Chapter Award Winners 2020

Award for Chapter Excellence

ACHE—Nevada Chapter
ACHE of the Triad
American College of Healthcare Executives of Central Florida
Central Texas Chapter—ACHE
Sandhills Healthcare Executives Forum
Triangle Healthcare Executives' Forum

Award of Chapter Distinction

ACHE of North Texas
Alabama Healthcare Executives Forum
American College of Healthcare Executives—Rhode Island Chapter
Arkansas Health Executives Forum
Central Illinois Chapter of ACHE
CT Association of Healthcare Executives
East Tennessee Healthcare Executive Affiliation
Georgia Association of Healthcare Executives
Healthcare Executive Forum, Inc.
Kentucky ACHE Chapter
Puerto Rico Chapter of the American College of Healthcare Executives, Inc.
San Diego Organization of Healthcare Leaders
South Texas Chapter of the American College of Healthcare Executives
Texas Midwest HealthCare Executives

Award of Chapter Merit

ACHE—MN Chapter
ACHE—North Florida Chapter
ACHE of Iowa
ACHE of Middle Tennessee
ACHE of Western PA
California Association of Healthcare Leaders
Colorado Association of Healthcare Executives
Greater Charlotte Healthcare Executives
Hawaii-Pacific Chapter of ACHE
Health Care Management Association of Central New York
Idaho Healthcare Executive Forum
Kansas Association of Health Care Executives
Maryland Association of Health Care Executives
Midwest Chapter of the American College of Healthcare Executives
Montana ACHE Chapter
National Capital Healthcare Executives
Network of Overseas Healthcare Executives
Sooner Healthcare Executives
South Dakota Healthcare Executive Group
Utah Healthcare Executives
Western Florida Chapter

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
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
Midwest Chapter of the American College 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.

Col Wade B. Adair, FACHE, administrator, 99th Medical Group (Mike O’Callaghan Military Medical Center), Nellis AFB, Nev., received the Senior Career–Mentor Leadership Award from the Regent for Air Force.

Srilalitha Akurati, student, University of Illinois at Chicago Cancer Center, received the Health Studies Student Leadership Award from the Regent for Illinois—Metropolitan Chicago.

Nora M. Bota, community health program specialist, County of San Diego Health & Human Services Agency, received the Early Career Healthcare Executive Award from the Regent for California—Southern.

Melissa A. Conway, FACHE, assistant director, VA Boston Healthcare System, received the Early Career Healthcare Executive Award from the Regent for Veterans Affairs.

LCDR Celerina L. Cornett received the Early Career Healthcare Executive Award from the Regent for California—Southern.

Paul S. Crews, FACHE, director/CEO, Durham (N.C.) VA Health Care System, received the

Senior-Level Healthcare Executive Award from the Regent for North Carolina.

Dasha Dahdouh, business analyst, Rady Children’s Hospital–San Diego, received the Early Career Healthcare Executive Award from the Regent for California—Southern.

Pranav Dixit received the Early Career Healthcare Executive Award from the Regent for California—Southern.

Lt Col Jason Estes, FACHE, director, operations, United States Air Forces in Europe, received the Mid-Career Leadership Award from the Regent for Air Force.

Amir Farooqi, FACHE, interim director/CEO, Central Alabama Veterans Health Care System, received the Senior-Level Healthcare Executive Award from the Regent for Navy.

MAJ Jessica Forman, chief of business operations, Brooke Army Medical Center, Fort Sam Houston, Texas, received the Early Career Healthcare Executive Award from the Regent for Army.

Meeta Gandhi, manager, operations, Novant Health, Winston-Salem,

N.C., received the Early Career Healthcare Executive Award from the Regent for North Carolina.

Capt Tamiko T. Gheen, FACHE, health services administrator, U.S. Air Force, received the Junior Leadership Award from the Regent for Air Force.

Heather Jacobson, strategic service associate, Duke Health, Durham, N.C., received the Early Career Healthcare Executive Award from the Regent for North Carolina.

Alex Langhart received the Early Career Healthcare Executive Award from the Regent for Mississippi.

COL Richard S. Lindsay III, FACHE, chief of staff/deputy director, Transitional Intermediate Management Organization, Bethesda, Md., received the Career Achievement Award from the Regent for Army.

Robert P. McDivitt, FACHE, network director/CEO, VA Midwest Healthcare Network VISN 23, Minneapolis, received the Senior-Level Healthcare Executive Award from the Regent for Veterans Affairs.

Michael Nowicki, EdD, FACHE, professor, health administration, Texas State University, Round

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This column is made possible in part by Envision Physician Services.



Rock, Texas, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Central & South.

Jennifer Pawlowski, senior practice transformation coach, Delaware Valley ACO, Villanova, Pa., received the Early Career Healthcare Executive Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Donald M. Peace Jr., PhD, FACHE, dean, College of Health Professions, Anderson (S.C.) University, received the Senior-Level Healthcare Executive Award from the Regent for South Carolina.

Robert Redden-Huff, operational lead, care standardization, ChristianaCare, Wilmington, Del., received the Early Career Healthcare Executive Award from the Regent for Delaware.

Emily K. Rhine, physician relations manager, Ascension Healthcare, St. Louis, received the Early Career Healthcare Executive Award from the Regent for Texas—Central & South.

Maj Sean D. Rotbart, FACHE, medical service corps officer, U.S. Air Force, received the Early Career Healthcare Executive Award from the Regent for Navy.

Christopher R. Sandles, FACHE, medical center director, South Texas Veterans Health Care System, San Antonio, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Central & South.

Thomas E. Skorup, FACHE, vice president, applied solutions, ECRI Institute, Plymouth Meeting, Pa., received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Charles D. Stokes, FACHE, founding partner, Relia Healthcare Advisors, Houston, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Southeast.

Brian E. Sweeney, FACHE, divisional COO, Thomas Jefferson University Hospitals, Philadelphia, received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Renee Taylor, clinical director, Memorial Hermann Texas Medical Center, Houston, received the Senior-Level Healthcare Executive Award from the Regent for North Carolina.

LTC Joshua C. Thompson, FACHE, plans officer, Blanchfield Army Community Hospital, Fort Campbell, Ky., received the Senior-Level Healthcare Executive Award from the Regent for Army.

Heather L. Wargo, FACHE, senior client program manager, Lumeris Inc., St. Louis, received the Exceptional Leadership Award from the Regent for North Carolina.

Jeanenne B. Watters, RN, FACHE, director, medical staff services and regulatory readiness, FirstHealth of the Carolinas, Pinehurst, N.C., received the Exceptional Leadership Award from the Regent for North Carolina.

Adrienne E. White-Faines, FACHE, CEO, American Osteopathic Association, Chicago, received the Healthcare Leadership Award from the Regent for Illinois—Metropolitan Chicago.

Larry S. Wrobel, DHA, FACHE, MHA program director/clinical assistant professor, Master of Healthcare Administration program, University of Illinois at Chicago, received the Career Achievement Award from the Regent for Illinois—Metropolitan Chicago.

Want to submit? Send your “Member Accolades” submission to he-editor@ache.org by Aug. 3 to be considered for the November/December 2020 issue.



Programs and Services at the Local Level

Chapters continue to be a source of value for members.

Whether you want to volunteer, strengthen your leadership skills or become a Fellow, your local chapter is an excellent place for networking, professional development and career advancement opportunities.

During today's unprecedented events, chapters are providing valuable services and programs, including many that are conducted virtually. Below are examples of chapters small and large from across the nation that are offering their members exceptional experiences.

Exam Preparation in Central New York

Health Care Management Association of Central New York has been focusing on preparing its members to take the Board of Governors Examination in Healthcare Management. The chapter has developed an Exam prep course. The complimentary prep course is composed of monthly, 60-minute webinars that cover one section of the Exam and is facilitated by the chapter's volunteers. The chapter's board members developed the program based on what they learned from other chapters that had successful prep courses.

Connecticut Association of Healthcare Executives Pivots to Virtual Events

Connecticut Association of Healthcare Executives had just hosted two in-

person events before the COVID-19 pandemic flooded Connecticut. The chapter quickly realized members serving on the front lines would still need support and education and pivoted to a virtual platform to provide them.

CTAHE scheduled a series of virtual networking sessions. The first one, Virtual After 5, was held April 1, and there were over 30 participants, who were so excited to see, connect and learn from each other. Everyone noted that even though they were so busy, this hour provided a refresh to connect with their fellow leaders and see that they were not alone. The chapter also hosted a successful virtual coffee chat, "Leading from a Distance," which offered coaching tips to those who were managing remote workforces.

The chapter is partnering with neighboring chapters in Rhode Island and Massachusetts, as it was determined that COVID-19 education, lessons learned and best practices via webinar were necessary. The first webinar, "Digging Deep: Lessons Learned from the Field to Care for Yourself and Your Colleagues During Times of Prolonged Stress," hosted by American College of Healthcare Executives—Rhode Island Chapter, had over 300 registrants.

Lots of Variety in North Carolina

In 2020, Sandhills Healthcare Executives Forum is working to add one or two Student Associates to the board—the chapter would allow them to attend its meetings/events at no cost.

SHEF created a new website using association management software, which is also used to more efficiently set up its meetings and store all chapter documents. The chapter now has the capability to send out notifications of any events, announcements and links to its new Facebook and LinkedIn accounts. SHEF is also on Twitter and Instagram. The chapter did not have a website or a social media presence prior to the board's annual strategic planning session.

SHEF is also pushing to enhance its role in helping its members take the Board of Governors Exam by adding an Exam workshop. The chapter's goal is to increase the number of members who take and pass the Exam in 2020.

Engaging, Collaborating in the Sunshine State

ACHE of South Florida has been focusing on rebranding, engagement and collaboration strategies. This effort began with a name change, a new logo and a redesigned website. Formerly known as South Florida Healthcare Executive Forum, Inc., the chapter wanted to better align itself with ACHE so the affiliation was clear to members. The redesigned website will enhance the user experience with a more professional image and ease of navigation.

ACHE of South Florida will continue to collaborate with other organizations, such as the National Association of Health Services Executives, on

appropriate educational topics and networking events. This collaborative effort will help achieve diversity among chapter members and the topics and panelists it offers. This strategy can also help the chapter recruit members by increasing its visibility in the community.

ACHE of South Florida has committed to greater membership engagement in 2020, which it plans to achieve through sending monthly email communications to all members, highlighting important information. The chapter is also enhancing its visibility on social media to better engage members and share their stories. Additionally, its new website will allow members to interact with the chapter, obtain information and register for events. The chapter also

plans on hosting events geared toward specific groups, such as Fellows, sponsors and students.

Virtual Mentor Relationships in Utah

Utah Healthcare Executives has refreshed its mentoring program so members can sign up and connect with mentors through the chapter's homepage. Prior to this development, mentor participation was solicited on an annual basis by mentoring committee members, and mentors were matched with mentees via an overly cumbersome process. The new process allows for greater mentor flexibility and participation and a more diverse mentor pool for mentees to select from. UHE's mentoring committee will engage with participating mentors on an annual basis. Specific criteria related to willingness and

frequency of engagement are in place for mentors who wish to post their profiles and allow mentees to engage with them in a mentoring relationship. Mentees must be members of ACHE to be considered for the program. It is up to the mentors to decide how many mentees they will engage, and the process is set up to be more automated than previously. These updates to the mentorship program have only been in place since January 2020, and feedback thus far has been positive. ▲

To find your chapter or search the chapter directory, go to ache.org/Chapters. To discuss your ideas for chapters, contact Jennifer L. Connelly, FACHE, CAE, vice president, Department of Regional Services, at (312) 424-9320 or jconnelly@ache.org.

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American College of
Healthcare Executives
for leaders who care[®]

ETHICS SELF-ASSESSMENT

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](https://www.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.

I. LEADERSHIP	Almost Never	Occasionally	Usually	Always	Not Applicable
I take courageous, consistent and appropriate management actions to overcome barriers to achieving my organization's mission.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I place community/patient benefit over my personal gain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I strive to be a role model for ethical behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work to ensure that decisions about access to care are based primarily on medical necessity, not only on the ability to pay.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My statements and actions are consistent with professional ethical standards, including the <i>ACHE Code of Ethics</i> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My statements and actions are honest, even when circumstances would allow me to confuse the issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I advocate ethical decision-making by the board, management team and medical staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use an ethical approach to conflict resolution.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I initiate and encourage discussion of the ethical aspects of management/financial issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I initiate and promote discussion of controversial issues affecting community/patient health (e.g., domestic and community violence and decisions near the end of life).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promptly and candidly explain to internal and external stakeholders negative economic trends and encourage appropriate action.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use my authority solely to fulfill my responsibilities and not for self-interest or to further the interests of family, friends or associates.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When an ethical conflict confronts my organization or me, I am successful in finding an effective resolution process and ensuring it is followed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate respect for my colleagues, superiors and staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate my organization's vision, mission and value statements in my actions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I make timely decisions rather than delaying them to avoid difficult or politically risky choices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
I seek the advice of the ethics committee when making ethically challenging decisions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My personal expense reports are accurate and are only billed to a single organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I openly support establishing and monitoring internal mechanisms (e.g., an ethics committee or program) to support ethical decision-making.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I thoughtfully consider decisions when making a promise on behalf of the organization to a person or a group of people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take responsibility for understanding workplace violence and take steps to eliminate it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

I personally devote time to developing solutions to community health problems.

I participate in and encourage my management team to devote personal time to community service.

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.

Patients and Their Families

I use a patient- and family-centered approach to patient care.

I am a patient advocate on both clinical and financial matters.

I ensure equitable treatment of patients, regardless of their socioeconomic status, ethnicity or payer category.

I respect the practices and customs of a diverse patient population while maintaining the organization's mission.

	Almost Never	Occasionally	Usually	Always	Not Applicable
I demonstrate through organizational policies and personal actions that overtreatment and undertreatment of patients is unacceptable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I protect patients' rights to autonomy through access to full, accurate information about their illnesses, treatment options, and related costs and benefits.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote a patient's right to privacy, including medical record confidentiality, and do not tolerate breaches of this confidentiality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am committed to eliminating harm in the workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am committed to helping address affordability challenges in healthcare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Board</i>					
I have a routine system in place for board members to make full disclosure and reveal potential conflicts of interest.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ensure that reports to the board, my own or others', appropriately convey risks of decisions or proposed projects.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work to keep the board focused on ethical issues of importance to the organization, community and other stakeholders.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I keep the board appropriately informed of patient safety and quality indicators.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote board discussion of resource allocation issues, particularly those where organizational and community interests may appear to be incompatible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I keep the board appropriately informed about issues of alleged financial malfeasance, clinical malpractice and potentially litigious situations involving employees.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Colleagues and Staff</i>					
I foster discussions about ethical concerns when they arise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I maintain confidences entrusted to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate through personal actions and organizational policies zero tolerance for any form of staff harassment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
I encourage discussions about and advocate for the implementation of the organization's code of ethics and value statements.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I fulfill the promises I make.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am respectful of views different from mine.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am respectful of individuals who differ from me in ethnicity, gender, education or job position.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I convey negative news promptly and openly, not allowing employees or others to be misled.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect and hold staff accountable for adherence to our organization's ethical standards (e.g., through performance reviews).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate that incompetent supervision is not tolerated and make timely decisions regarding marginally performing managers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ensure adherence to ethics-related policies and practices affecting patients and staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sensitive to employees who have ethical concerns and facilitate resolution of these concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage the use of organizational mechanisms (e.g., an ethics committee or program) and other ethics resources to address ethical issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I act quickly and decisively when employees are not treated fairly in their relationships with other employees.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I hold all staff and clinical/business partners accountable for compliance with professional standards, including ethical behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
<i>Clinicians</i>					
When problems arise with clinical care, I ensure that the problems receive prompt attention and resolution by the responsible parties.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I insist that my organization's clinical practice guidelines are consistent with our vision, mission and value statements and ethical standards of practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When practice variations in care suggest quality of care is at stake, I encourage timely actions that serve patients' interests.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I insist that participating clinicians and staff live up to the terms of managed care contracts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage clinicians to access ethics resources when ethical conflicts occur.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage resource allocation that is equitable, is based on clinical needs and appropriately balances patient needs and organizational/clinical resources.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect and hold clinicians accountable for adhering to their professional and the organization's ethical practices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Buyers, Payers and Suppliers</i>					
I negotiate and expect my management team to negotiate in good faith.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am mindful of the importance of avoiding even the appearance of wrongdoing, conflict of interest or interference with free competition.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote familiarity and compliance with organizational policies governing relationships with buyers, payers and suppliers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I set an example for others in my organization by not accepting personal gifts from suppliers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Adopting a Systematic Approach to Bringing Healthcare Executives Into a New Position or Organization

November 2009

November 2014

November 2019

Statement of the Issue

Having a strong leadership team is key for any organization. However, when leaders undertake a new role, whether in their current organizations or a new one, there are potential risks to both the organization and the individual's success. Such personnel changes alter the composition of a leadership team and, if unsuccessful, can negatively impact organizational effectiveness and efficiency, as well as the individual's own career.

For the organization, the nature of risk may be dependent on the role and level of the newly introduced professional. At the departmental level, an unsuccessful transition may be revealed in diminished productivity, deteriorating quality of service and decreased team morale. At the organizational level, unsuccessful leadership transitions have been linked to increased external threats by competitors in the form of new marketplace initiatives and attempts to recruit key employees and physicians. Internal threats include instability in leadership positions and the postponement or cessation of important initiatives such as physician recruitment, community outreach, strategic planning and new service development.

For the individual experiencing an unsuccessful transition, associated risks include diminished prospects for further career advancement, economic hardship and emotional distress stemming from a failure.

In an effort to decrease the risks that occur when individuals take on a new role or join a new organization, many leading organizations have adopted onboarding systems for executives and high-level directors.

Policy Position

The American College of Healthcare Executives encourages healthcare executives and their organizations to adopt a systematic onboarding process that ensures leaders undertaking new roles receive the necessary support to increase their potential for success. Components of the process include the following initiatives:

Design and implement a carefully planned and structured acculturation process that moves the leader into the new role as quickly and as efficiently as possible. The goal should be for the individual to sufficiently understand the new role, its organizational context, goals and objectives and key relationships in order to reach a point of effectiveness with the fewest missteps possible. The process should be in writing and contain as much detail as necessary for successful implementation, including assignment of accountabilities for various action steps in the onboarding process and a means to document progress.

- Adopt a longitudinal, phased approach to onboarding, including the following:
 - Use prework in advance of the actual start date in order to clarify expectations. Ideally, expectations would be delineated as measurable objectives that can be tracked in the first year.
 - Provide an assessment to the individual that helps him/her identify his/her skills and opportunities for development and how well they align with organizational expectations.

- Prepare the organization for the arrival of the leader and aid the selected candidate in building communication bridges with key individuals.
 - Create a first-days-on-the-job schedule that establishes a formal process for the new leader to become well acquainted with key staff members and by which the new individual conveys personal values and core expectations and begins building solid relationships and trust.
 - Establish the first weeks on the job as a period of active listening on the part of the new leader to learn more about the organization, its departments, and the associated people and systems, rather than a focus on immediate actions.
 - Ensure during the first month on the job that the new leader establishes and employs a system to identify, sort and manage priorities and specific measurable goals, distinguishing between short-term and long-term initiatives.
 - Devote sufficient time during the first months to ensure the new incumbent and the direct supervisor systematically work to develop the foundation for a productive relationship, agreeing on the attainment of unambiguous mutual expectations related to the content of the individual's job and to organizational priorities.
- Provide the new leader with knowledge and insight about the organization's culture and heritage. Understanding culture and the social organization are as important as learning the strategy and operations focus.
 - Allow for the basics in educational training and do not cut corners on training that is required for others. Subordinates are aware of norms, policies and processes and other leadership expectations.
 - Consider assigning a mentor—someone who is not the individual's direct supervisor—to be a sounding board, monitor progress on the onboarding plan and provide feedback and been-there-done-that kinds of intelligence to help the new leader navigate organizational dynamics that may not be evident. A key priority for the mentor could be to accelerate the new leader's attainment of knowledge of expected leadership competencies and norms within the environment.
 - Support opportunities for the newly installed leaders to achieve early substantive successes that will demonstrate effectiveness and help build personal credibility. At the same time, recognize that a new leader's propensity to make fast and positive first impressions may be inappropriate; provide counsel as necessary.
 - For the new leader that has relocated from another community, ensure attention is given to helping the spouse/significant other and family get introduced to the community and its resources. In addition, if the individual has relocated alone, it is equally important to pay attention to community introduction and inclusion to ensure he/she does not become isolated outside of work.
 - Encourage the newly installed leader to monitor his/her progress in achieving onboarding goals and to consider sharing his/her assessments with his/her supervisors to demonstrate accomplishments and ensure priorities remain aligned.
 - Establish similar acculturation processes for new clinical leaders who may have had limited executive experience in their earlier professional roles.
 - Systematic and comprehensive onboarding has become a routine best practice in many industries. Healthcare organizations, too, should capitalize on the advantages of onboarding realized by individuals and organizations by adopting a well-structured process.
- Approved by the Board of Governors of the American College of Healthcare Executives on Nov. 18, 2019.*



Strengthening Healthcare Employment Opportunities for Persons With Disabilities

May 1992

May 1995 (revised)

December 1998 (revised)

March 2002 (revised)

November 2006 (revised)

November 2009 (revised)

November 2019 (revised)

Statement of the Issue

Despite the passage of the Americans with Disabilities Act in 1990, disability, whether actual or perceived, presents an ongoing employment challenge in our society. Even in the case of healthcare organizations, which face periodic personnel shortages in administrative, clinical and support functions, persons with disabilities may not be sought after as willing, productive resources for employment.

Obstacles to including the disabled in the pool of potential employees may be related to misperceptions about accommodation and healthcare costs, productivity losses, reliability of workers, how to access potential candidates, and, in many communities, the lack of reliable transportation. There is a perception that significant infrastructure investments and systematic process modifications may be needed to achieve organizational compliance with regulations such as those included in the Americans with Disabilities Act. However, research suggests that the additional costs to accommodate employees with a disability may be minimal or nonexistent and that people with disabilities have lower rates of turnover and absenteeism (Job Accommodation Network, 2009).

There is evidence that healthcare organizations may already be more likely to employ those with disabilities than organizations in other sectors. While in 2009 4% of all civilian workers were disabled, a 2005 survey of

members of the American College of Healthcare Executives showed a somewhat higher rate, with an estimated 7.6% of respondents being disabled, defined as having a condition that limits full participation in work and/or having specific conditions such as learning, emotional or mental disability or disease; a sensory impairment; physical handicap; pain; or chronic fatigue syndrome.

The prevalence of disability in our society, and the responsibility of healthcare leaders to lead by example, creates a particular responsibility for healthcare executives to be vigilant in ensuring ongoing opportunities for persons with disabilities while fostering an inclusive environment with equitable workplace treatment for all.

Policy Position

ACHE believes healthcare executives should take the lead in their organizations to increase employment, advancement and leadership opportunities for persons with disabilities. Additionally, healthcare executives should advocate on behalf of the employment of persons with disabilities in other organizations in their communities.

ACHE encourages all healthcare executives to pursue the following actions:

- Develop an organizational culture that is inclusive of the abilities of persons with disabilities to utilize their potential to contribute to the mission of a healthcare

organization. Create ongoing programs to educate those within human resources departments/divisions, supervisors and co-workers on disability awareness.

- Affirm that equal access to employment for persons with disabilities exists by recruiting governance leaders, executives, clinicians and support staff with auxiliary aids and services (such as Braille or large-print materials, telecommunication devices for deaf persons and videotext displays); through using networks and recruiting firms committed to accommodating persons with disabilities; and by making auxiliary assistance available throughout the interview process.
- Reallocate or redistribute job responsibilities to accommodate individuals with disabilities and consider reallocating responsibilities to accommodate and retain individuals already on staff who acquire a disability.

- Determine appropriate accommodations using an informal, interactive problem-solving process involving the employer and the individual with a disability. The employer may wish to seek the assistance of a third party who is knowledgeable in disability matters, such as a vocational rehabilitation counselor.

The American College of Healthcare Executives encourages its members to take the lead in their organizations and their communities in creating working environments that enhance the opportunities of persons with disabilities to gain and maintain employment.

Approved by the Board of Governors of the American College of Healthcare Executives on Nov. 18, 2019.

Are You Stimulating or Stifling Your Rising Stars? 7 Rules

In working with organizations to place mid-level executives, the expectation is that many up-and-coming leaders—the “rising stars” or “high potentials”—will one day fill senior-level roles and shape the future.

One mistake leadership makes, at times, is that their ideas for promoting rising stars are not always in line with what those individuals actually want. There can be a disconnect, and in some cases the initiatives meant to encourage up-and-coming executives end up discouraging them instead.

The following are rules for talent leaders to consider as they establish effective strategies for rising stars:

1. Define what a rising star or high potential looks like in your organization. A lot of companies presume that these are the most visible and vocal employees in their ranks or are simply junior versions of current senior executives. That’s often not the case at all. Carefully consider and specify what designates the next-generation stars in your organization, and question your assumptions about who those individuals are.

2. Don’t assume everyone wants to climb the ladder. Beware of conveying an “up or out” culture. Many ambitious professionals get to a point where they are quite comfortable and impactful at their current employment level and pay grade. There can be great value in allowing them to achieve success in these roles long term. Besides, realize that not all high performers are high potentials. According to George Hallenbeck of the Center for Creative Leadership, high potentials “tend to be broad and adaptable in their learning and skills,” which is not necessarily true of all high performers, many of whom may have “narrow but deep” expertise.

3. Communicate and mentor. Tease out rising leaders’ aspirations in regular meetings with supervisors.

Millennials in particular like to have feedback on how they are doing and talk about themselves and their careers—not in an egotistical manner but as a means of figuring out or even course correcting their futures. In addition, they are very open to and, I believe, energized by being mentored. Creating a culture that encourages mentoring and regular feedback will pay great dividends in terms of retaining rising stars.

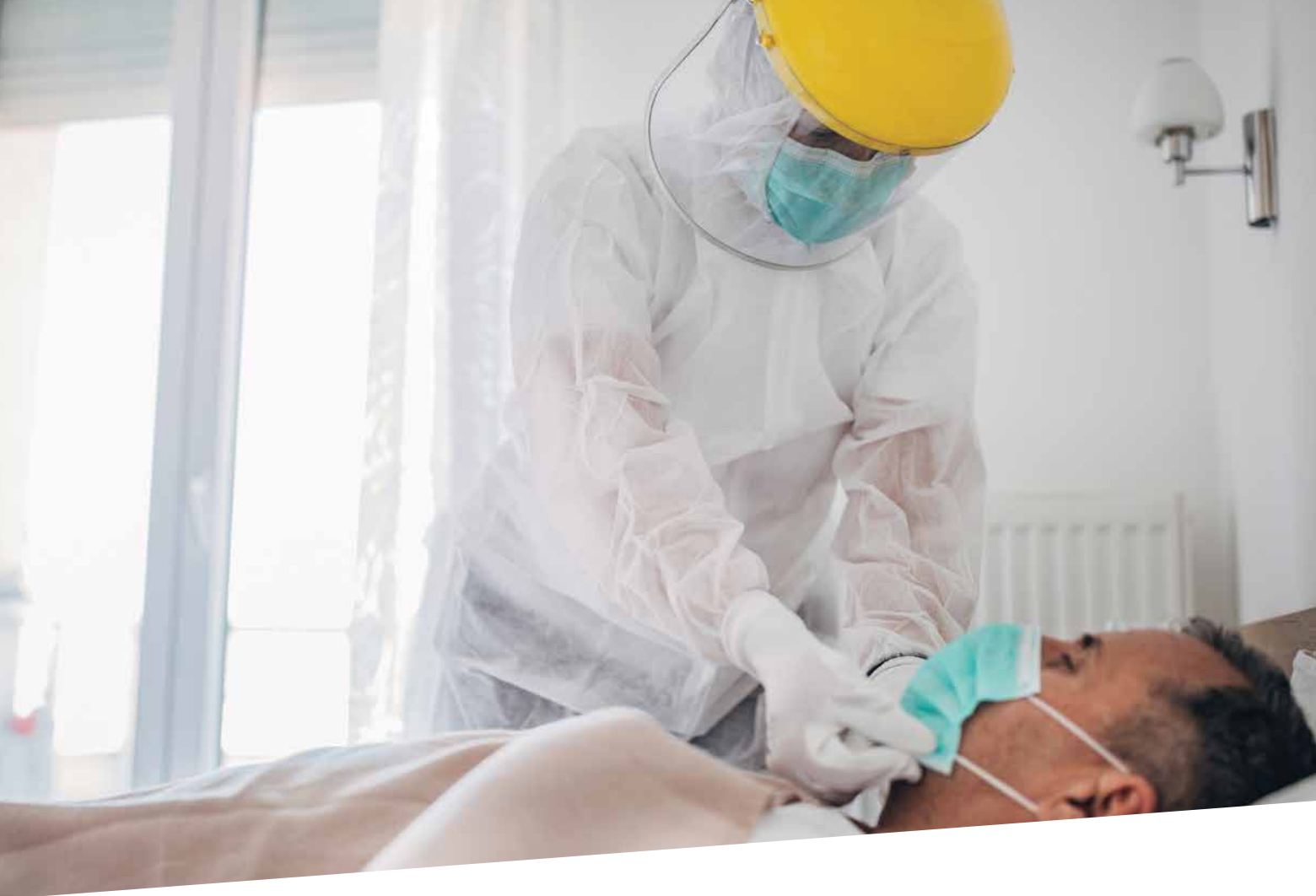
4. Nudge, but don’t rush. It’s important to provide opportunities and encourage rising stars to take on new challenges above and beyond their normal responsibilities—new committee work or education/training opportunities, for example. Don’t expect immediate results, as it can be hard for talented professionals to juggle new tasks with their core responsibilities. Take the long view, including providing resources for high potentials over many years.

5. Let them call the shots. Up-and-coming talent must have relative autonomy to decide what works for them in terms of career progression. They may have entirely different ideas about what constitutes work-life balance than their seniors in the organization. They may want to get ahead but still within a 9-to-5 or even flex work schedule. Listen to them rather than prescribe or layer on your own expectations.

6. Link high-potential strategy to diversity promotion. Identifying and encouraging women, minorities and diverse professionals as rising stars is an effective way to improve leadership diversity. Dedicate mentors and resources to this cause, with the understanding that diverse candidates know very well whether a company is truly committed to diverse leadership.

7. Accept attrition. Not all rising talent will stay. This will always be true, so know that you are investing in high potentials for their personal gain and that some will leave the fold to pursue other opportunities.

Adapted from an article by David Boggs, senior partner and practice leader, mid-level executive search, Witt/Kieffer. Visit wittkieffer.com.



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