HEALTHCARE EXECUTIVE

POPULATION HEALTH'S
NEXT FRONTIER

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Much has changed within population health management over the years. Yet, more changes are on the horizon as the field continues to evolve in the drive for high quality while squeezing out unnecessary costs.

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In "Healthcare Quality and Safety: A Conversation With **Robert Otto Valdez, PhD**," the director of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, discusses the organization's objectives for improving safety and quality of healthcare for all Americans.

A Deep Dive Into A Transforming Concept

Randy F. Liss

As we produce each issue of *Healthcare Executive*, we strive to cover the emerging issues and trends that are driving healthcare leaders' agendas. One of the things I enjoy most about our work is the opportunity not only to see how a topic we're exploring is evolving, but also to learn where it's going.

That's exactly what this issue offers on the topic of population health, a relatively new concept two decades ago that has become a vital part of care delivery. Our cover story, "Population Health: The Next Frontier" (Page 8), delves into this gradual transformation, and leaders immersed in this work share how they expect it to change and expand even further. Spoiler alert: technology, further integration and reimbursement all will be huge drivers.

Speaking of change, one area of healthcare that has evolved rapidly in a brief window of time is virtual care. And while usage dipped as COVID-19 waned, experts estimate that if fully implemented, it would improve access and quality while reducing spending—which is population health at its essence. One expert puts it well in our second feature, "Virtual Health's Potential" (Page 16): "Virtual health needs to be part of the equation for every organization."

I hope you enjoy this issue. If you'd like to share any feedback about it, just send me a note at rliss@ache.org. ▲

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Reinvesting in the Workforce: Our Most Valuable Asset

Deborah J. Bowen, FACHE, CAE

New approaches can help us keep our people safe.

Our collective mission to advance the health and well-being of the people and communities we serve simply doesn't happen or move forward without the workforce, an indispensable part of patient care and the engine that makes the entire healthcare system run. Developing, supporting and safeguarding those on the front lines is as urgent and vital a priority as anything on the agenda, if not more so—both a fundamental aspect of leadership and an ethical imperative.

Given that, it's troubling to see statistics showing the difficulties some front-line workers are experiencing. For example, a 2023 survey of hospitals by Press Ganey found that reported assaults against nurses increased 5% from 2022 and have risen nearly 25% since 2019. Also, research by the Centers for Disease Control and Prevention showed that the number of healthcare workers who reported harassment at work in 2022 more than doubled since 2018. The CDC report also noted that nearly half of healthcare workers reported often feeling burned out, up 32% in that same time span.

This intersection between workforce violence and front-line mental health can seem like a new normal—a stubborn, post-pandemic trajectory that is proving challenging to reverse. Addressing it may require new solutions, and two areas could offer fresh thinking to leaders.

Technology. Predictive analytics and AI algorithms are becoming prominent parts of healthcare organizations, and tech experts believe they can play a role in employee safety by making it easier to report, analyze, anticipate and prevent safety issues and events. Also, training with virtual reality systems may allow employees to "experience" realistic scenarios to better prepare them to respond effectively in specific situations, including harassment or violence.

In the nearer term, establishing digital reporting systems and using incident reporting software can encourage front-line workers to report events while standardizing how such events are recorded. Smart devices and wearables already are used in some hospitals to keep situations from escalating, but they also can monitor employees' physical condition, such as their heart rate. Experts say compiling the data they generate into a dashboard that provides a real-time snapshot of how people are doing could offer great benefit in a patient-care setting.

Culture. Some of the same lessons about culture-building that help organizations thrive can also make the workforce safer. All of us strive to build a strong culture that stresses trust and respect, but the connection to workforce safety might not always be so apparent. Ensuring all of our people can feel safe at work—through ongoing education, training, collaboration and transparency—might make all the difference.

This moment offers an opportunity to recommit to safety as a core value and prioritize workforce safety within it, by doubling down on front-line mental health and well-being while strongly encouraging speaking up and reporting. Tying safety culture to a healthy organizational culture like that could go a long way to helping provide the physical and psychological safety people need.

New resources also offer guidance. This year the CDC's National Institute for Occupational Safety and Health released its *Impact Wellbeing Guide* to help leaders bolster professional well-being with their staff. Also, the American Hospital Association published a new issue brief, "Building a Safe Workplace and Community: Violence Mitigation in a Culture of Safety," that examines how hospitals' violence mitigation efforts can fit effectively into an organization's safety strategy. Both offer key takeaways that place the workforce at the forefront of safety efforts.

Finally, this issue includes ACHE's *Ethics Self-Assessment*, which provides the opportunity to reflect on your own actions regarding the workforce, among other areas. Our people are what make patient care what it is today, and reinvesting in their safety can help provide the best outcomes for all those we serve. ▲

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

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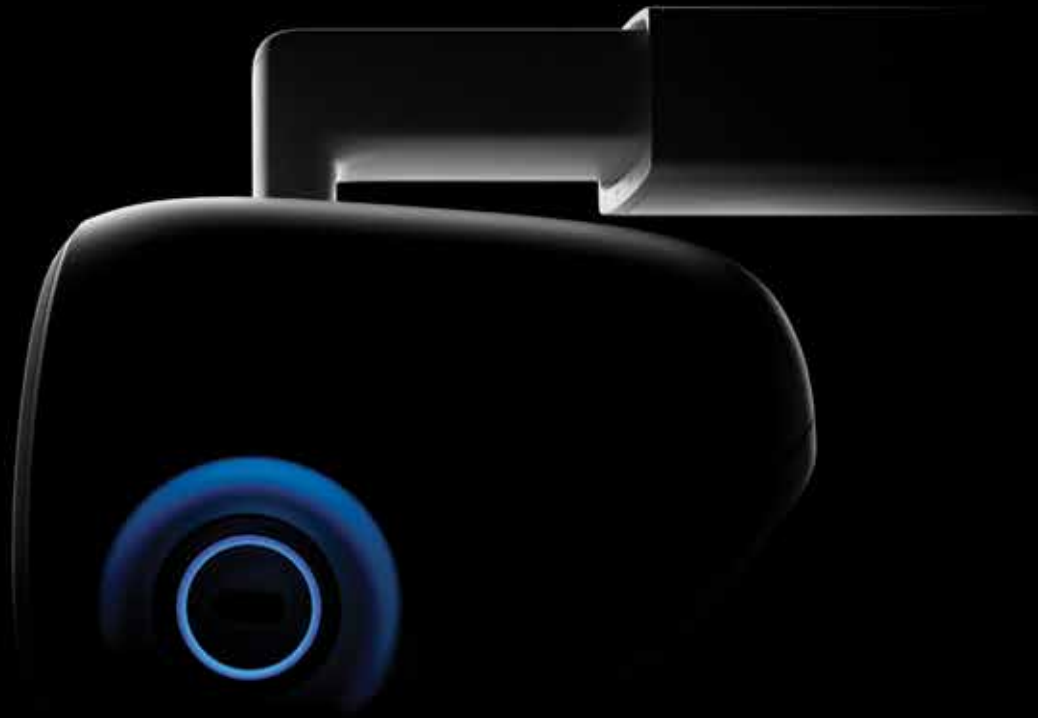
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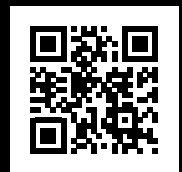
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POPULATION HEALTH'S NEXT FRONTIER

By
Karen
Wagner

M onica Puga, RN, recalls when value-based care was considered a passing trend. Rebecca Adkins remembers the days of a registered nurse using a spreadsheet to analyze data on a population of patients. Nick Macchione, FACHE, thinks back to his time during the 1990s managing AIDS patients. And, Jessica Diamond, FACHE, remembers when payers began to focus on clinical outcomes.

Today, all of these healthcare leaders hold or have held executive roles in population health management, as many organizations in the past several years have created C-suite and senior-level positions to oversee the transition from fee-for-service to value-based care.

From mindsets about value-based care to the tools, technologies and care teams used, much has changed within population health management since the early days of these executives' work. Yet, there is much more change on the near horizon as the field continues to evolve in the constant drive to attain a system of care that strives for high quality, while squeezing out unnecessary costs.

Each of the executives above has worked in the population health field for over a decade. The changes they describe and what they forecast present a snapshot of how the work and their roles have evolved and how population health management will continue to transform over the next several years.

Population Health Takes Center Stage

The culture has changed considerably since the days when Puga says she heard phrases like "flavor of the month" in reference to value-based care. "I also think that value-based care got a bad rap because when people see the word 'value' in front of 'care,' they think it means cheap care," says Puga, an ACHE Member. Puga began in population health management about 10 years ago helping build the IT infrastructure for population health data analytics in the EHR for Memorial Healthcare System, a six-hospital system in Hollywood, Fla. Back then, "people didn't really understand the underpinnings of value-based care," she says.

Currently Memorial Healthcare System's chief nurse executive, Puga says moving the needle meant changing mindsets through provider education and storytelling about patient success stories with population health management strategies. Now, value-based care also is part of the organization's strategic imperative.

As with the culture, the work itself—in terms of scope, clinical teams and technology—has also undergone significant transformation in the past decade or so.

"The work has evolved tremendously," says Rebecca Adkins, RN, senior vice president of Population Health at Philadelphia-based Jefferson Health, a network of 18 hospitals and physician practices, a health plan and Thomas Jefferson University.

In her early population health work at Jefferson Health, a few nurse navigators used spreadsheet analysis to manage patients in the few value-based contracts in the health system's portfolio at the time. It was an entirely new area of work. "You were building the ship as you were sailing it," she says. "Now, there are sophisticated software platforms to support value-based care. Everything from the financial modeling to the care coordination."

> "Value-based care got a bad rap because when people see the word 'value' in front of 'care,' they think it means cheap care."
>
> —Monica Puga, RN
> Memorial Healthcare System

The focus of population health work has also expanded. Adkins says when she first started in the field, a high-risk patient was identified as someone with three or more chronic conditions. Now, risk stratification takes into account patient utilization, medication use and socioeconomic factors—data that is tracked by high-functioning population health management tools whose benefits include care efficiencies.

"The technology allows you to risk stratify in a more sophisticated way to support the right resource at the right time," Adkins says.

When payers began to scrutinize clinical outcomes and set quality goals, Jessica Diamond, who has worked in population health management for federally qualified health centers since 2015, says she began partnering with a CMO to shift provider focus from treating disease to managing and preventing disease. Diamond and her team created patient panels for primary care, and providers were held accountable for clinical outcomes for these populations. Along with setting up new dashboards of population health data, the team also provided training and education to providers on the shift from fee-for-service to pay-for-performance, the precursor to value-based care.

"Now, we're in a world where we're talking about taking on full financial risk for a population," says Diamond, who now serves as executive director of New York-based FQHC Housing Works. "To do that successfully, you have to be equipped to have pretty advanced population health management tools."

This expansion of risk factors to include the so-called social determinants of health (factors such as access to food, housing and transportation) represents a reframing of what it takes to keep a population healthy. It isn't just prescribing a steroid medication for an asthma patient, for instance. Traditional medical interventions and preventive

measures are now recognized as no longer sufficient by themselves. Integrating behavior health and social services into population health management has become standard.

"We can't think that just our clinical information alone is going to help us understand risk levels—who's likely to be a no-show or remain disengaged," Diamond says. "We have to really begin taking our social needs data and incorporate that into how we stratify our patients."

Reaching Beyond the Four Walls

Just as healthcare providers are looking beyond medical conditions to determine a person's health status, they are also realizing the need to reach beyond their own four walls to truly capture and address the needs of populations within their communities. Consequently, population health efforts are increasingly involving community partnerships, community investments and the community in general.

For example, 30% of patients at Housing Works are HIV positive, and many are unhoused, which complicates or prevents their ability to follow prescribed care, Diamond says. To address the housing issue, Housing Works has invested in 500 single-room housing units across the city.

> "We are working with community partners every single day to reach those populations to provide services that we ourselves are not able to provide. They really are that trusted resource."
>
> —Rebecca Adkins, RN
> Jefferson Health

"It's those types of drivers that have to be in place to stabilize an individual," she says.

Last August, Memorial Healthcare System created a social determinant of health hub, which, with help from community partners such as food banks, faith-based organizations and financial aid providers, ensures that patients get the resources they need outside of medical care. As of May, the hub has served more than 1,000 patients, each being referred for an average of three socioeconomic needs, Puga says.

Jefferson Health partners with various community-based organizations to provide services to address population health needs. "We are working with community partners every single day to reach those populations to provide services that we ourselves are not able to provide," Adkins says. "They really are that trusted resource."

Nick Macchione, chief health officer for UC San Diego Health, La Jolla, Calif., says his three decades of work in public health, from the East Coast to the West, made him realize the importance of integration of providers of all kinds—medical, behavioral, social services, law enforcement—in keeping populations healthy and safe.

His experience and insights into population health management led Macchione to be part of creating a strategy incorporating three arenas—health, safety and the built environment. Called Live Well San Diego, the program, begun in 2010, counts 560 hospitals, federally qualified health centers, municipalities, schools, faith-based organizations, private businesses and a variety of other organizations as partners in creating safe corridors and a healthy environment for San Diego County's 3.3 million residents. The partners align their efforts offering resources to residents; they do not work under a contract, but what Macchione calls a "public handshake."

"We're moving from a collaborative nature to a more integrative nature of how to do your work," Macchione says. "The key is looking outside your walls, thinking

broadly of that ecosystem, and when you do, that's when you move beyond that collaborative to integrative, and even become a generative ecosystem, that provides healthier dividends—care, quality and access—to the patient and generally for the population."

Today, as chief health officer, the only role of its kind in the university's system, Macchione sees himself as having one leg in the hospital and one leg in the community.

"It's been pretty extraordinary," he says of the role he's served in for slightly less than a year. "The community is coming to me for advice with how to handle population health challenges. It's about creating the bridge that is connecting the two worlds."

What Lies Ahead
Key themes for what's next in population health management revolve around what can propel the work forward or perhaps stymie its progress: technology, further integration and reimbursement.

New tools, for everything from stratifying patient risk and predicting ED visits to patient engagement and outreach, are upping the level of input and output for population health management.

UC San Diego Health created a community information exchange, which is similar to a health information exchange except that instead of clinical data, the CIE collects data from human services providers such as food banks, shelters and other social services agencies. Such combined data allows population health teams to attain a clearer picture of a patient's needs and who is meeting those needs, reducing waste and ineffectiveness in the care delivery system and instead providing whole patient care through an integrated network of providers and agencies, Macchione says.

"That HIE and CIE connectivity is the digital backbone for population health," he says.

Perhaps not surprisingly, the most significant transformation in population health management may come with greater use of artificial intelligence, especially for customizing patient care.

> "Now, we're in a world where we're talking about taking on full financial risk for a population. To do that successfully, you have to be equipped to have pretty advanced population health management tools."
>
> —Jessica Diamond, FACHE
> FQHC Housing Works

With $25 million in private funding, UC San Diego Health is setting up a Center for Health Innovation, which will serve as an AI-supported "air traffic" command center for population health management, Macchione says. Using data from the HIEs and CIEs, the AI tool is expected to be able to perform such functions as identifying gaps in patient care that have the potential to lead to negative outcomes and then suggest preventive measures.

For example, for an asthmatic patient who is about to be discharged, the AI tool will be able to determine whether the patient is likely to have any obstacles for managing symptoms in the home environment, such as a lack of air-conditioning—an important piece of data because hot weather can negatively impact air quality and aggravate asthma. The hope is that AI will also develop a solution for that patient—all before discharge, Macchione says.

"That's going to bring population health to the high next level," he says.

Housing Works' Diamond also views AI as a game changer, but she says the health center is proceeding with caution for fear of exacerbating health disparities. Closing the disparity gap is crucial to a population health strategy, but using AI or machine learning has to be built and staff trained so it reflects the populations being served.

"If not, then they're going to be flawed from the start, and they won't help us adjust the health disparities that we know

exist," Diamond says. "It's critical in population health management and to me from a mission and corporate perspective that we really ensure any insight that we get from technology is not further perpetuating the disparities."

Memorial Healthcare System's Puga sees greater collaboration across the continuum of care, from acute care hospitals and ambulatory care to behavioral health care, skilled nursing care, home care and community care such as food banks and housing shelters. "We can no longer work in organizational silos," she says. "We have to effect change across the care continuum and make healthcare more frictionless, more seamless."

Puga also believes that the business models will have to change to support work in social determinants of health. Accreditation agencies, such as The Joint Commission, are already requiring assessments for socioeconomic factors. "I expect to see a major shift," in the business model, she says.

> "We're moving from a collaborative nature to a more integrative nature of how to do your work that provides healthier dividends—care, quality and access—to the patient and generally for the population."
>
> —Nick Macchione, FACHE
> UC San Diego Health

Richard Ashenoff, Memorial Healthcare System's vice president of value-based care, sees more risk-based contracts to support value-based care. He says there needs to be better alignment of incentives, specifically for physicians. Ashenoff says he is trying to educate employers on pushing their health plan carriers to offer such deals by incentivizing physicians in their networks to agree to value-based care contracts. He believes the Centers for Medicare & Medicaid Services is headed in this direction.

"The commercial payers will follow suit shortly thereafter. It's definitely on everyone's radar," Ashenoff says. "So, it's really incumbent on us to align incentives, reward the behaviors we want and incentivize providers for doing the right thing."

Diamond agrees that matching reimbursement and rates to population health services will loom larger over the next few years. She points to the accelerated use of telemedicine during the COVID-19 pandemic, when she says telehealth visits at Housing Works skyrocketed from 3% of patient visits to about 98%. Now, her advocacy team has been working with legislators to lobby for appropriate reimbursement and developing an advocacy plan in conjunction with other community health centers.

"This type of transformation would have normally taken 10 years, but it took really weeks, if not days. Now we're trying to figure out the right balance of in-person and virtual care," she says. "So, there's a lot of advocacy that needs to be done to … take lessons learned from the pandemic and ensure we're reimbursed accordingly," she says.

Population health has come a long way since its infancy, but as with any other endeavor in healthcare, it's still about finding the right support—both financially and strategically.

"Managing value-based contracts," Diamond says, "is how to find the right community-based partners and also risk-bearing entity partners that can provide the best financial support and insights to allow them to be successful in managing the population and benefit accordingly."

Karen Wagner is a freelance writer based in the Chicago area.

Late might be too late.

Approximately 60 million adult Americans aged >45 years are currently **unscreened for colorectal cancer (CRC).**[1,2*]

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*Based on 2022 USA single-year census estimates for ages 45-85 inclusive and the percentage of unscreened subjects. Does not account for variable screening rates across age ranges.[1,2]

†These data are from a 2019 retrospective analysis of Kaiser Permanente healthcare system patients who died of CRC between 2006 and 2012 (n=1750).[3] EHR=electronic health record.

References: 1. United States Census Bureau. Annual estimates of the resident population by single year of age and sex for the United States: April 1, 2020 to July 1, 2022 (NC-EST2022-AGESEX-RES). April 2023. Updated December 18, 2023. Accessed December 20, 2023. www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html **2.** American Cancer Society. Colorectal Cancer Facts & Figures 2023-2025. Atlanta: American Cancer Society; 2023. **3.** Doubeni CA, Fedewa SA, Levin TR, et al. Modifiable failures in the colorectal cancer screening process and their association with risk of death. *Gastroenterology*. 2019;156(1):63-74.

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Virtual Health's Potential

By Susan Birk

Questions remain around a host of issues pertaining to health, notably reimbursement and ensuring that the models and systems implemented drive access and quality gains that justify costs. But few in healthcare would dispute that virtual health has earned a permanent place in care delivery following its swift ascent in 2020.

Telehealth is not and never could be a pure substitute for in-person visits, according to Thom Bales, U.S. health services sector lead at PwC. But, he says, "providers can look at it as an essential lever for increasing access to care, efficiency and clinician productivity. All health systems and physician groups need to make sure they have competitive capabilities in this space."

Indeed, when it comes to population health, it's hard to disagree with the argument that telehealth "makes care more equitable and accessible to the 89% of U.S. adults and 78% of adults globally who own a smartphone, including those in medically underserved communities," as Robert Pearl, former CEO of the Permanente Group, Oakland, Calif., and Bryan Wayling of Intermountain Healthcare, Salt Lake City, write in the May/June 2022 issue of *Harvard Business Review*. "Any nation seeking to raise health care quality, increase access and lower costs should be expanding, not contracting, the use of virtual care," they say.

What Virtual Health Can Do

Virtual health offers major opportunities in five areas, according to Pearl and Wayling, all with implications for population health: reducing unnecessary and expensive ED visits, stemming the chronic disease crisis, reducing disparities in care, improving access to specialty care and connecting patients with the doctors most knowledgeable about a particular disease regardless of geographic location. They estimate that full implementation of telehealth services in these areas would improve clinical quality nationwide by 20%, increase access to care by 20% and reduce health care spending by 15% to 20%.

Bales believes the effective implementation of these services for population health management revolves as much around traditional workforce management involving

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decisions regarding scheduling and productivity as it does around digital technology. This is because technology has progressed to a place where many organizations already have telehealth capabilities embedded in their EHRs.

He notes that the trend toward physician employment can help organizations in this regard because the employment structure lends itself more readily to rallying groups of clinicians around specific population health goals.

A Necessary Part of Patient Care

Though telehealth utilization rates remain higher than before the pandemic, Centers for Medicare & Medicaid Services data show decreases in most areas other than behavioral health services since telehealth's precipitous rise with COVID-19's onset.

Still, virtual health remains "a necessary and urgently needed modality of care," stresses Kyle Zebley, senior vice president of public policy at the American Telemedicine Association, in a statement in March, citing virtual health's power to remove geographic barriers, expand clinically appropriate options and help clinicians reach more people more efficiently.

Bales sees a bright future for virtual services in population health management that extends beyond primary care and behavioral health to specialty care, hospital at home and home care platforms, and as a vehicle for monitoring medication

adherence, particularly among polypharmacy populations. Some of that is already happening, but telehealth still holds great potential, he says.

"Virtual health needs to be part of the equation for every organization around improving quality and affordability and allowing clinicians to practice more productively at the top of their license," he says.

Yale New Haven Health System: Building on Lessons From a Crisis

As a system affiliated with a major medical school, Yale New Haven Health is something of an early adopter in the use of virtual services for population health management. The five-hospital system had invested in telehealth before the pandemic and strengthened its use during the pandemic, according to Polly VanderWoude, FACHE, executive director, population health and clinical integration.

"The fact that we had a commitment to technology-enabled care pre-COVID and were already building capabilities internally positioned us to rapidly deploy virtual services to keep our physicians connected with their patients," she says.

Yale New Haven Health set up a national COVID-19 call center that fielded questions and triaged patients, as well as a home-based monitoring program that included, among other things, providing pulse oximeters to patients for home use and daily logging of vital

We Lead for Safety

Aiming for zero harm across your organization? ACHE offers two notable practioner-created resources that share this common safety initiative. *Safer Together: A National Action Plan to Advance Patient Safety* focuses on safety from a total system approach, and *Leading a Culture of Safety: A Blueprint for Success* focuses on leaders, equipping them with a comprehensive guide to oversee care delivery.

Both resources complement each other well and can be used in tandem when leading towards a future of zero harm in healthcare.
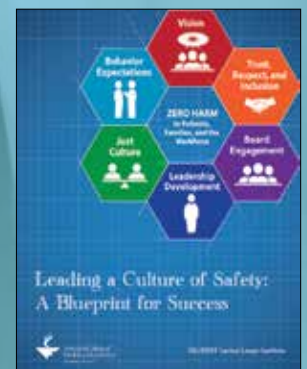
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Virtual Health's Potential

"Virtual health needs to be part of the equation for every organization around improving quality and affordability and allowing clinicians to practice more productively at the top of their license."

—Kyle Zebley
American Telemedicine Association

signs into the patient portal. That home-based program is "an early example of how we were able to use virtual technology to keep patients safe and in their homes while reducing the burden on our care teams and care sites," she says.

The system is spreading those same clinical triage capabilities across its primary care sites and post-discharge outreach teams for many other conditions. "The concept is to use the same types of algorithms, tools and home assessments developed during the pandemic to direct patients to the right site of care or enable them to stay home," VanderWoude says. To date, these programs have generated favorable satisfaction ratings and engagement with a protocol of outreach phone calls to patients following hospital discharge to schedule follow-up visits, resolve prescription and medication issues, and provide clinical triage if necessary.

Among the options available to patients is receiving an on-demand virtual visit. "What was originally stood up as a community resource for COVID is now the backbone of how we triage and stay connected with patients," she says.

The system offers a digital cognitive behavioral therapy tool for patients who have a referral from their primary care physicians. Brought to the population health team through the YNHH Center for Health Innovation, the novel technology holds promise as a cost and resource savings strategy in an area of high demand. A third of

patients showed 50% improvements on Patient Health Questionnaire measures of mental health following engagement with the tool, VanderWoude reports.

In addition, after an initial pilot for patients with hypertension, YNHH is expanding a remote patient monitoring program to include patients with diabetes and congestive heart failure patients, as well. "We see the ability to keep patients in their homes using technology-enabled virtual services as a critical part of increasing access to care," she says.

VanderWoude stresses the importance of remaining sensitive to the needs of front-line clinicians in virtual health services trials and roll-outs. "One of our biggest lessons learned was the value of ongoing communication with clinicians about how a service will help them care for their patients while relieving some of their clinical burden; having front-line clinicians engaged in our project teams has been critical to ensuring programs that are sensitive to how they and their patients experience digital health offerings," she says.

Kaweah Health: Generating Access for a Population in Need

With eight hospital campuses and a network of rural health clinics spanning Tulare County and surrounding areas, public nonprofit Kaweah Health, Visalia, is the largest healthcare district in California as well as the county's leading acute care provider. Located in the heavily agricultural Central Valley,

the health system serves one of California's largest low-income populations, including thousands of migrant farm workers. It ranks highest in the state in percentage of patients covered by Medi-Cal.

The system had already been strategizing about telehealth and reviewing vendors for a year and a half when the pandemic began, says Ryan J. Gates, PharmD, chief population health officer, and an ACHE Member. But those solutions required patients to set up an account before they could access the platform. In the heat of a crisis, "those options presented barriers that were not going to work for our community," Gates says.

Instead, as the pandemic loomed, the system chose a simple, affordable solution that essentially created a HIPAA-compliant FaceTime. "We had our first telehealth visit on that platform within seven days of the pandemic washing up on our shores," he says.

Reflecting trends across the country, more than 40% of Kaweah Health's outpatient visits were virtual at the pandemic's peak. Today, that figure hovers between 10% and 15%. To mine telehealth's potential and raise that number now that the dust has settled from the pandemic, the system is developing virtual services targeted to its underserved population's most pressing needs.

One of those needs is hypertension. Another is diabetes, which has an

The Future of Telehealth Reimbursement

Dec. 31, 2024, could mark the end to many of the Medicare telehealth flexibilities put in place during the COVID-19 pandemic—flexibilities that enabled millions of Americans to receive care in the safety of their homes and demonstrated telehealth's convenience and viability for consumers as well as clinicians.

This past May, however, the U.S. House Energy and Commerce Subcommittee on Health approved a two-year extension of many of the pandemic-era rules, as well as a five-year extension of the Acute Hospital Care at Home Program before the scheduled expiration date.

The subcommittee also advanced legislation that would expand the Medicare diabetes prevention program to allow virtual participation and provide a two-year extension for virtual cardiac and pulmonary rehabilitation services.

Though numerous bills have been introduced, much of telehealth's future depends on two key pieces of legislation: the CONNECT for Health Act (H.R. 4189, S. 2016) and the Telehealth Modernization Act, which would, among other things:

- Make Medicare telehealth flexibilities implemented during the pandemic permanent.

- Ensure affordable telehealth services for the commercially insured, including patients with high-deductible health plans, by permanently extending the exemption for telehealth services.

- Ensure affordable telehealth coverage for part-time, contracted workers who don't qualify for healthcare coverage.

- Remove the in-person requirement for the remote prescribing of controlled substances.

Virtual Health's Potential

> "For chronic diseases that are intensely managed with high-risk medications, telehealth can play a big role in getting patients controlled faster and safer."
>
> **—Ryan J. Gates**
> PharmD, Kaweah Health

incidence rate in Tulare County that is double the state average. "For chronic diseases that are intensely managed with high-risk medications, telehealth can play a big role in getting patients controlled faster and safer," Gates says. Despite the area's considerable number of low-income residents, the fact that almost everyone in the service area has a cell phone works in the system's favor.

The first step has been identifying which types of visits and follow-up can best be handled virtually. "It's all about program design and making sure the patient is deeply engaged in their care at home," Gates says.

While the initial training around blood glucose monitoring and insulin injections for diabetes patients must be done in person, "the next three visits can and should be convenient, quick check-ins," he says. Telehealth is a natural for those follow-ups and offers a huge advantage in an area like Tulare County, in which transportation is a significant problem and many people don't get paid for time off from work.

Similarly, for hypertension, though in-person training on collecting an accurate blood pressure reading on a home device is needed, telehealth's convenience makes it a shoo-in for this patient population as well, according to Gates.

To develop programs around these and other population-based virtual services, Kaweah Health has begun

working with a solution chosen for its ease in connecting with Bluetooth devices for in-home monitoring and sending data to the EHR.

The system has partnered with health plans to provide remote monitoring devices. "The level of engagement needed for remote monitoring requires patients who are fairly tech-savvy, but we know it's possible to achieve that," he says.

Though it's poised to move ahead, like many organizations, the system is grappling with balancing the costs of virtual technology against the risks associated with lingering uncertainties around reimbursement and utilization, Gates says. "Should we pause before we make massive investments in tele-infrastructure?" he says. "Will the investment deliver a return that improves health? That's why we feel a sense of urgency to not let up on refining and integrating virtual services that will produce results at the population level."

Amid issues of equity, a workforce shortage, an older, sicker baby boom generation and the growing burden of chronic disease, virtual health stands out as a tool with huge promise. Clarity around reimbursement and knowing how to bring that promise to fruition remain a work in progress.

Susan Birk is a Chicago-based freelance writer specializing in healthcare.

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Transparency and Trust

Both are necessary for effective, ethical information sharing.

Susan A. Reeves, EdD, RN, CENP

All healthcare leaders aspire to build and sustain ethically aligned organizations that engender trust with those they serve. They want their patients and families to trust that care delivered will be safe and of high quality, that services will be available when needed and that the organization's business objectives consider the needs of those served. Those who work within healthcare organizations wish to work in safe, secure and respectful environments, and they want honest, routine and understandable communication from leaders about performance and achievement of the organization's objectives. Transparency—the sharing of key data, information and decision-making—is considered a means to achieving these desirable ends.

A full commitment to transparency often requires a leader's discernment, commitment and courage to share "the good, the bad and the ugly." And, often, this requires keen ethical judgment and decision-making that helps leaders determine how and when information is best shared and when sharing can do more harm than good.

Defining Transparency
In his book, *The Speed of Trust*, Stephen M.R. Covey describes transparency as being based on the principles of openness, honesty, integrity and vulnerability: "telling the truth in a way that others can verify." Covey describes the opposite of transparency as hiding, covering, obscuring and secret-keeping, as well as having hidden objectives, agendas and meanings.

When deployed responsibly, transparency has the power to enhance trust in our organizations.

In these descriptions, one can easily grasp the relationship between transparency and trust, with transparency being seen as critical to establishing and sustaining a high-trust organization. Everyone appreciates being dealt with honestly and in a way they can understand. Conversely, no one likes the sense that leaders or organizations are not "being straight" with them or are spinning data and information in a way that obscures reality.

Appreciating this and genuinely wishing to nurture trust with their patients, their staff and their communities, healthcare leaders often have important decisions to make. Such decisions include whether information can and should be shared, the timing of information sharing, the depth and complexity of information to share, and the proper communication mechanisms that best convey the information for greatest understandability. Following are several examples that highlight these considerations.

Balanced Transparency
In the 1990s, as the quality improvement wave came to healthcare, there was mounting pressure for hospitals to publicly disclose their performance outcomes with respect to indicators such as mortality rates, complication rates for specific procedures, readmission rates and other such data. The initial pushback on this notion was strong, and concerns about the public's ability to interpret this complex data were high. Many worried that the disclosures would, in fact, have the opposite effect of building trust and instead erode public confidence in the healthcare system and its providers.

For example, if a higher mortality rate was attributed to one hospital in a region versus another, one might be tempted to believe that one organization was safer to receive care at than the other. Of course, those of us who lead healthcare organizations know myriad factors that have nothing to do with care quality or clinician expertise can contribute to a higher mortality rate. But the complexity of explaining these factors to the uninitiated (not just the public but, importantly, our employees) is daunting and certainly not suited to a paragraph in a local newspaper.

In the early 2000s, I remember thinking that one of our physicians,

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the leader of our bone marrow transplant program, was practically a pioneer for agreeing to publicly disclose multiple quality and patient outcome indicators for his program, particularly because some were not in the "excellent" category. I remember this physician's passion for moving toward greater transparency, as he believed it made the program better and more accountable to those served. He was right. Colleague and patient responses were positive. Many of his colleagues decided to follow suit.

One of the resulting positive effects was the learning that ensued among colleagues who wanted to know how to improve their personal and their clinical program's performance. As we all know, these and similar efforts began a push for greater accountability from the healthcare field. Today, healthcare organizational performance and quality data are not only publicly reportable and available, they are also accessible to anyone via simple internet searches.

Responsible Transparency
Covey and *The Speed of Trust* contributor Rebecca R. Merrill are quick to point out that there must be a responsible balance with transparency. Obviously, information that is confidential, highly sensitive or private should not be disclosed. Nor should transparency be performed irresponsibly, with information being disclosed in ways that are "too much or too fast." Two examples come to mind.

A healthcare organization's recent restructuring led to about 100 people losing their jobs. There was a lot of pressure placed on leaders to publish a listing of those individuals. This pressure came from an altruistic place: People wanted to reach out and support those affected and to understand who might now be taking those employees' places so that various workflows could continue. In this instance, the leaders did not succumb to the pressure for transparency. They decided that it was more important to protect the affected employees' confidentiality and did not publish the list.

....

A full commitment to transparency often requires a leader's discernment, commitment and courage to share "the good, the bad and the ugly."

....

Another example of transparency's role in healthcare is related to the COVID-19 pandemic. There was a time during the pandemic's height when healthcare organizations were scrambling to create their crisis standards of care, the policies and procedures for how hospitals would make decisions regarding rationing of scarce resources should it become necessary. The plans were elaborate and complicated, comprising special triage committees, scoring instruments and decision-making algorithms.

Once the crisis standards of care were completed, leaders in my organization began to receive calls to publish these documents to the entire organization as well as the public. Several spirited discussions ensued. On one side, strong opinions noted the need for full transparency as well as people's "right" to have this information.

On the other side was concern about placing additional (and potentially unwarranted) stress on the already anxious organization and community, particularly given how unlikely it was that the crisis standards would ever need to be implemented.

There was grave concern that publishing the standards might cause people to forgo urgent and emergent care out of fear that hospitals would not provide it. Both the organizational and clinical ethics committees wrestled with this transparency dilemma. In the end, a decision was reached that the crisis standards would not be released in full form. Instead, the hospital provided employees and the community assurance that a plan existed and outlined what was included, demonstrating responsible transparency.

The Power of Transparency
The push for greater transparency in healthcare is ever-increasing. For example, calls for price and cost transparency headline healthcare news outlets, as do demands from the public for disclosure about adverse events and their remediation.

When deployed responsibly, transparency has the power to enhance trust in our organizations. It makes us more accountable to all we serve—our patients, our communities and our people. As leaders, we need to make sure to carefully consider all the motivations for and potential effects of transparency and be prepared to respond to the outcome. ▲

Susan A. Reeves, EdD, RN, CENP, is system chief nurse executive for Dartmouth Health, headquartered in Lebanon, N.H. (Susan.A.Reeves@ hitchcock.org).

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Stephany Nihipali
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Caring for Vulnerable Patients With Complex Needs

Lessons from the Kahua Ola framework.

In 1855, Alexander Liholiho ʻIolani became King Kamehameha IV at age 20. On April 7, 1855, the young king gave a renowned speech on a subject that he felt "in comparison … all others sink into insignificance." He urged, "Our acts are in vain unless we can stay the wasting hand that is destroying our people. I feel a heavy and special responsibility resting upon me in this matter, but it is one in which you all must share."

The framework was adapted from "the Hawaiian worldview," a holistic paradigm that provides a Hawaiian perspective on health and well-being.

This quote underscores The Queen's Health System's enduring commitment to its mission, one that aligns with the vision of the system's founders, King Kamehameha IV and Queen Emma. It serves as a poignant reminder that their aspirations remain relevant today: Despite the passage of time, Native Hawaiians still experience lower life expectancy compared to other ethnic groups, emphasizing the need to address persistent health inequities. The work of The Queen's Health System's Native Hawaiian Health department is dedicated to improving the health and well-being of Native Hawaiians in honor of the health system's founders.

The Queen's Health System is a nonprofit healthcare organization with a rich history of caring for the people of Hawaii. It consists of four hospitals and more than 70 preventive, specialty healthcare facilities and labs throughout the Pacific region. The health system's 10-year aspirational goals include:

- To extend the life expectancy and a life well lived of Native Hawaiians.

- To close the gap in life expectancy in half within the decade.

- To become a lifetime partner, improving the health and well-being of all those served.

Execution of Kahua Ola: Supporting Transformational Change

The Kahua Ola framework is foundational to the health system's 10-year aspirational goals and its Kahua Ola Strategic Plan. The framework was adapted from "the Hawaiian worldview," a holistic paradigm that provides a Hawaiian perspective on health and well-being that is multidimensional and honors ancestral wisdom. It provides a basis for unity, harmony and balance for good health versus illness. The Hawaiian worldview definition can be found in the February 2020 issue of the *Journal of Indigenous Voices in Social Work*.

Why is the Native Hawaiian Health Strategic Plan Kahua Ola so important? The COVID-19 pandemic all but erased slight improvements in the gap in life expectancy for Native Hawaiians, which is now seven years shorter than Hawaii's other major racial and ethnic groups. The U.S. Department of Health and Human Services Office of Minority Health reports that leading causes of death among Hawaiians are cancer, heart disease, stroke and diabetes. The 2023 Centers for Disease Control and Prevention's Pregnancy Mortality Surveillance System reported that the highest pregnancy-related mortality ratio in the U.S. was among Native Hawaiians and other Pacific Islanders at 62.8 deaths per 100,000 live births. These maternal deaths were due to cardiovascular conditions, infection/sepsis,

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cardiomyopathy, hemorrhage, embolism, hypertension and stroke. In addition, the 2021 Healthcare Association of Hawaii Community Health Needs Assessment identified five significant health needs affected by the COVID-19 pandemic in Hawaii: financial security, food security, mental health, housing, and trust and equitable access. Other studies, including the 2023 U.S. Census Bureau's American Community Survey, indicate Native Hawaiian communities often face challenges in accessing healthcare due to factors such as geographical remoteness, cultural preferences, housing instability and transportation difficulties.

These health disparities indicate the importance and urgency for Queen's Health System to meet its founders' mission. Native Hawaiian Health is integral to providing culturally safe and responsive, high-quality health services to Native Hawaiians. In 2023, The Queen's Health System received federal designation as a Native Hawaiian health center. The health system currently serves just over 110,000 Native Hawaiians, representing 38% of the approximately 289,776 Native Hawaiians in Hawaii.

By 2030, Queen's Health System aims to increase the number of Native Hawaiians served to 145,000, or 50% of all Native Hawaiians residing in Hawaii. Organizationally, Native Hawaiian Health has system-wide oversight and kuleana (responsibility) to implement the healthcare strategy for attaining this Queen's Health System aspirational goal:

Reduce in half the seven-year Native Hawaiian lifespan gap and increase their quality of life by 2030. The Kahua Ola strategy continues to evolve and achieves this aspirational goal by addressing the health disparities and health equity challenges described above.

Key Lessons Learned
Since Kahua Ola Strategic Plan 1.0 was approved in June 2019 (fiscal year 2020), there have been many valuable learnings through the collection of quantitative, qualitative and anecdotal data and lessons from the Kahua Ola implementation. One of the most notable learnings is that Native Hawaiians across the pae ʻāina (island group) still face barriers to accessing care and have limited access to culturally responsive and safe care. This is particularly true for those experiencing patient related or geographic factors such as poverty, poor health literacy, lack of social support, other social determinants of health or rural isolation.

Moreover, the health system has learned that there are many factors within Queen's Health System that contribute to or exacerbate patient factors and limit the organization's ability to provide access to care or to adequately engage Native Hawaiians in care. These system barriers (lack of financial resources and data collection challenges specific to Native Hawaiians) have posed challenges in the scalability, speed, development, expansion and sustainability of Kahua Ola programs and activities to support strategic plan execution. Financial resources alone are not sufficient to solve resistance in scalability that

What We Are Learning … and Leaning Into

- Tailored interventions that address specific community needs, resources, socio-economic factors, cultural differences and health service disparities are critical to improving overall teen mental health in Hawaii.

- More work is needed to develop capacity in population health management tools, systems and processes.

- The health and well-being of caregivers is foundational to culturally responsive and safe care.

- Systemwide training in trauma-informed care and harm reduction is critically needed for caregivers at all points of entry.

- For Native Hawaiians, every connection matters. Relationships matter.

- The health of the ʻāina (land) is inherently tied to the health of the people.

- A cohesive, culturally informed community engagement strategy, process and protocols, adaptable for each community, are needed.

- Community engagement with key leaders reinforces the importance of valuing ancestral knowledge, wisdom, lived experience and self-determination. This is also true for patients.

continue to slow spending, hiring or resource allocation. True integration of Kahua Ola across Queen's Health System is needed to address gaps and ensure healthcare system transformation is possible.

Primary Care Behavioral Health Integration Program

One example of this integration already underway is the Queens North Hawai'i Community Hospital's Kahu a Ola (to shepherd to good health) program, a primary care behavioral health integration program launched in February 2019. The program provides integrated behavioral health services, chronic disease management, care coordination and community navigation through a culturally responsive lens within primary care at Queens North Hawai'i Community Hospital.

From its inception, the Kahu a Ola Program has supported Native Hawaiian patients with one or more of the following chronic diseases: Type 2 diabetes, hypertension or obesity. The program offers an array of services based on patient preference, including unique engagement activities such as nutrition and food preparation classes, hula, walk programs, and diverse webinars and in-person classes. As of the third quarter of fiscal year 2024, 142 patients were enrolled. ▲

Stephany Nihipali Vaioleti, JD, FACHE, is president, Queen's North Hawai'i Community Hospital, Waimea (Kamuela), Hawaii (svaioleti@queens.org). Darlena Chadwick, RN, FACHE, is executive vice president/COO, The Queen's Health System, Kapolei, Hawaii (dchadwick@queens.org).
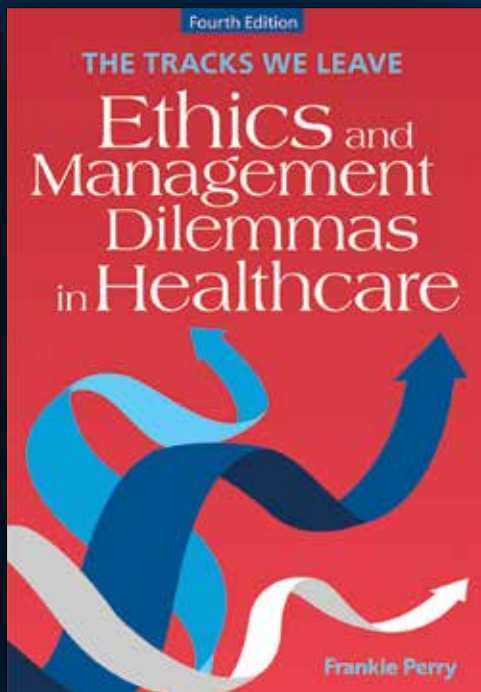
The Evolving Landscape of Primary Care

Key models and players: Implications for healthcare leaders.

Paul H. Keckley, PhD

Demand for primary care services in the U.S. is growing. The supply of service providers, however, is not. And, though the supply of advanced practice nurses is on the rise, the overall shortage of providers is likely to continue for the foreseeable future.

Data about the current primary care market—including pediatricians, general and family practitioners, internal medicine physicians and gynecologists—in the U.S. reflect both its attractiveness and challenges. Consider the following:

- Per the Centers for Disease Control and Prevention, 50.3% of all visits to physicians in 2023 were to primary care providers; 88% of adults and 98% of children say they have a primary care relationship, but one-third did not see their primary care providers last year.

- According to Grandview Research, primary care providers represented a $271.3 billion market in 2023, and it is forecast to increase 3.36% annually through 2030 versus a 5.5% annual increase in overall healthcare spending in the same period.

- Per University of Chicago research, PCPs earn 55% of what specialists earn.

- According to the Association of American Medical Colleges, the shortage of PCPs will be nearly 55,000 by 2033.

Policymakers, medical educators and public health experts widely recognize that primary care is a key to bending the healthcare cost curve and improving the population's health. Many of Medicare's alternative payment models, including the Medicare Shared Savings Program, are structured to engage primary care organizations as gatekeepers to lower costs and improve outcomes. Though each pilot program varies, CMS results have shown a consistent correlation between primary care engagement and shared savings in Medicare.

The landscape for primary care services is defined by three major models. Their business objectives, resources and critical success factors vary significantly.

1. **Hospital Sponsored Primary Care** (50-55% of the primary care services market)

   Business objective: The majority of community hospitals and health systems directly employ primary care clinicians. They function as part of their ambulatory services strategy and anticipation of

future value-based contracting opportunities with payers. The primary objective is to protect referrals to the hospital's acute programs and specialists. It's a defensive strategy for most since at-risk contracting with payers represents only 7% of total health spending today.

Resource considerations: Due to interest rates and thin operating margins, most hospitals face capital constraints. Operating losses in primary care practices from suboptimal payer reimbursement and regulatory limits on financial relationships mean employment agreements are based primarily (70-90%) on traditional productivity measures (relative value units) versus bonuses and shared savings (10-20%).

Critical success factors: PCP network effectiveness under hospital sponsors involves:

- the composition and structure of the entire care team—inclusive of nutrition, dental, behavioral services and advanced practice providers/nurse practitioners;

- the infrastructure (technology, data) enabling

monitoring of patient activities and their interactions across the system; and

- the convenience of patient access through digital portals, self-care services and insurance coverage conducive to primary care gatekeeping and risk sharing with care teams.

Payer-Sponsored Primary Care
(15-20% of the primary care services market.)

Business objective: Payer-sponsored primary care is focused on lowering total care costs for enrolled populations. Multi-disciplinary primary care is the centerpiece for aggressive referral management to in-network specialists and hospitals, adherence to formulary design and engagement with enrollees.

Resource considerations: Payers like Humana, Optum (United), Elevance, Blue Cross of FL and others operate primary care services through subsidiaries and under brands that enable enrollee awareness and use. Most are built on private practice acquisitions to which capital is directed for expansion. Some operate through contracts with private equity backed multi-market operators (Oak Street and Iora). Each plan's capital strategy is unique, but publicly traded national and regional insurers have unique latitude to expand profitably, vis-à-vis provider recruitment, new services and locations, digital capabilities and value-based contracting with employers, Medicare Advantage, Medicaid and state

marketplaces for individual/small company plans.

Critical success factors: The regulatory environment for national insurers is favorable, but investigations about business practices in Medicare Advantage, prior authorizations, marketing practices and others are increasing. In addition, mixed results in Medicare's alternative payment programs have pushed some employers to alternative models (direct primary care, on-site/near-site primary care) to reduce their costs more effectively. Ultimately, primary care physician satisfaction is critical: Non-disparagement and noncompete provisions in contracts are being challenged by clinicians who cite insurer encroachment in their clinical decisions.

2. **Retail Health** (15-25% of the primary care services market.)

Business objective: Walgreens, Best Buy, Amazon, CVS, Walmart and others view healthcare as a market ripe for consumerization and financial opportunity. The objective for each is to increase sales per square foot for their facilities by offering on-site/virtual primary care products and services for conditions conducive to self-care. The proximity of convenient locations, over-the-counter remedies, pharmacies and self-care devices—alongside "front store" products like cosmetics and groceries—enhance store revenues.

Resource considerations: The business fortunes and sustainability for retailers vary widely depending on their business models, locations

and value propositions to consumers. Some, such as Walmart and Walgreens, have stumbled in primary care execution. Others, such as Amazon-One Med and CVS-Oak Street, are doubling down on on-site primary care. Still others are creating hybrid models leveraging their unique locations and their core consumer base.

Critical success factors: Retail primary care is a bet that convenience, transparent pricing and information technologies, which enable evidence-based treatments and consumer relationship management, are the future. It is risky for drugstore retailers already facing margin pressure from insurer-controlled pharmacy benefits managers and online purchasing by consumers. Adoption by employers, insurers and consumers is vital to retail primary care's growth and sustainability.

All three models are set up around certain assumptions about primary care providers:

- They will be employed in bigger organizations long term.

- They will play a central role in increased risk-sharing arrangements with payers—both insurers and employers.

- They will face increased regulatory scrutiny of their business practices around equitable access, price transparency and clinical effectiveness, workforce diversity and more.

In addition, each model is integrating social determinants and behavioral

health in their clinical strategy and will face business risks in their core businesses. For hospitals, that means inpatient and specialty programs. For insurers, it's group insurance coverage. And for retailers, it's prescription drug fulfillment through technology-enabled alternatives.

For healthcare leaders, there are four things to consider:

- Program design: Team-based, whole-person-oriented primary care inclusive of physical, mental and social support is the future. An office-only, physical-medicine-only orientation is becoming obsolete.

- Primary care sponsor analysis: Routine monitoring of the investments, program offerings, economics and market acceptance for each emerging model is paramount.

- Market surveillance: Analysis of social and economic factors that drive demand to and away from primary care services is critical.

- Employment agreement review: Contracts with primary care physicians, nurse practitioners, dentists and psychologists/counselors should be revisited to assure continuity of care by a competent, accessible multidisciplinary team that's rewarded for results.

Primary care services' future is likely not a repeat of the past. Though not without risk, it is safe to say it's importance will increase. ▲

Paul H. Keckley, PhD, is managing editor of The Keckley Report *(pkeckley@paulkeckley.com).*

Leonard H. Friedman,
PhD, FACHE

Wayne Psek, MD, PhD

Developing Leadership Competencies for an Uncertain Future

The challenge for senior leaders is how to teach these skills.

An important truism in healthcare today is that change is the only constant. The external and internal environments are populated with new rules, regulations, devices and demands. These changes beg the question: How prepared are you to develop a pipeline of leaders for a future we cannot accurately predict?

If healthcare executives are going to flourish in the years to come, senior leaders should start now to strategically develop a workforce capable of navigating today's and tomorrow's changing environment. Through mentoring and executive coaching, senior leaders can help executives adopt five new leadership competencies and personal practices that will help prepare them and the organization for an uncertain future.

1. Emotional and Social Intelligence

For too long, some assumed that intelligence as measured by IQ was the critical measure of leadership and organizational success. While leaders must be competent at the technical part of their work, managing and leading well requires mastering psychosocial behaviors. There are five key elements to emotional intelligence: knowing one's emotions, managing emotions, motivating oneself, recognizing emotions in others and handling relationships. The field of social neuroscience—how biological mechanisms influence psychological and social behavior—is also expanding our understanding of social interactions or what some consider our "social intelligence." To help other leaders develop these skills, encourage mentees to reflect on why they do certain actions or say certain things and how to adapt their behavior and communication in social contexts. Given the centrality of human interactions at all levels in healthcare, each of these skills is vital for healthcare leaders.

2. Think Big Picture in Terms of Systems

Too often, each group, department or division within healthcare organizations operates independently to optimize their world without considering how others might be affected.

The challenge for highly effective healthcare leaders is to create organizations where the hardened walls of operational silos are transformed into "semipermeable membranes" that allow for the free flow of information and best practices out of one part of the organization into another. By demonstrating through your own actions that collaboration and cooperation are key to highly effective systems, senior leaders can help develop systems thinking across organizations, as well as competencies in how to build health systems that are capable of learning.

3. Change Management

Effective healthcare leaders accept the fact that when encountering change, everyone is giving up something, no matter how large or small. This sacrifice automatically triggers an emotional response that varies depending on the scope and intensity of the change at hand. Key elements of effective change management are ensuring staff are given a compelling reason for

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The Bottom Line

Through mentoring and executive coaching, senior leaders can help executives adopt five new leadership competencies and personal practices:

- Emotional and Social Intelligence
- Think Big Picture in Terms of Systems
- Change Management
- Adaptability to Chaos and Complexity
- Open-Mindedness and Introspection

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change, a clear sense of hope and optimism for the outcome of change, and adequate time to integrate the new change into their routine.

While change is constant, the human response to change is also constant. By sharing insights and experiences, senior leaders can help cultivate other leaders' abilities to lead change with the understanding that change management is an ongoing and continuous process.

4. Adaptability to Chaos and Complexity

Some days our organizations can be chaotic and complex. This observation aligns with how the universe actually works: Chaos and complexity are the norm. Organizations try to manage chaotic and complex behavior by imposing rules and regulations or policies and procedures. But how well are those working?

There is a compelling body of scientific and organizational literature that suggests over-controlling a complex system, such as a healthcare organization, has little chance of lasting success. An alternative is to present a few simple rules that apply throughout the organization and then consistently put them into operation. You can help up-and-coming healthcare leaders adopt this perspective and get all staff moving in the same direction and working with a common purpose by offering guidance on how to create a plan, or by demonstrating how you have handled similar situations. Share examples of how such actions have helped build resilience and allowed organizations where you have worked to maneuver through challenging times that were difficult to anticipate.

5. Open-Mindedness and Introspection

The future will bring new ways of experiencing the world around us, disrupting our models of the way the world works. Challenge leaders you are mentoring or coaching to consider how individual and social definitions of identity and diversity are morphing and how they will need to adapt to evolving patient and staff expectations. Emphasize the importance of letting go of preconceived ideas and biases and adopting new lenses to view the world. Self-reflection is a necessary competency to understand one's values, biases and mental models. Encourage early or mid-careerists to avail themselves of self-assessment instruments to gain greater self-awareness. Completing a competencies assessment can have a powerful impact on a leader's transition from good to great.

The challenge for senior leaders is how to teach these competencies. What's more, how do we continually demonstrate and improve upon these competencies in our own daily practice? The consistent execution of these competencies and sharing them with future leaders will make a profound difference in the performance of healthcare organizations now and in the future. ▲

Leonard H. Friedman, PhD, FACHE, is director of the MHA program at The George Washington University, Washington, D.C. (friedmal@gwu. edu), and Wayne Psek, MD, PhD, is assistant professor, Department of Health Policy and Management, The George Washington University, Washington, D.C. (psek@gwu.edu).

Board Backing a Necessity to Support CEOs in Philanthropy

Betsy Chapin Taylor, FAHP

Now is the time to elevate charitable giving on the leadership agenda.

The importance of philanthropy in healthcare continues to rise as organizations face challenges in securing adequate dollars to help them reinvest in their mission.

The Association for Healthcare Philanthropy's *2023 Report on Giving for FY2022* showed that charitable giving provides a return on investment of $4.96 for each dollar invested in fund development—a rate of return that far exceeds what's possible from any clinical service line. As a result, philanthropy has become essential to providing capital and operational dollars to achieve a healthcare organization's potential.

However, most CEOs today face the untenable position of needing to provide time and attention to philanthropy when it is not formally recognized as an organizational priority. As the board considers the potential of philanthropy as a revenue source to sustain the mission and strengthen strategy, it's time to formalize the CEO's role in advancing development.

Adding Development to the Job Description

As philanthropy has become a lever to organizational excellence, it can no longer be an optional role for the CEO. Governing boards can affirm the importance of philanthropy as a key revenue strategy and support the CEO's role in development activities by adding this role to the job description.

If participation to bolster this key revenue source is a leadership activity, the board should honor and evaluate it as part of the CEO's role. That means not only setting expectations but also aligning those expectations with performance evaluation criteria and at-risk incentives.

Adding philanthropy to the formal list of expectations provides a benefit to CEOs by removing a hurdle to dedicating time to it and by creating a mutual understanding of the CEO's role in supporting it as a vibrant and sustainable revenue source.

Facilitating Donor Relations

CEOs have been entrusted with the successful management and financial health of their organization, so it naturally follows that they would be obligated to take on a meaningful role in fund development. Simply, no other organizational leader is as effective in conveying the organizational vision for the future, instilling a sense of trust and confidence in the organization, or rallying internal resources and advocates.

This is particularly important to the donor relationship. With backing from the board, CEOs can bring the stature, prestige and credibility of their office in building stronger relationships with donors. CEOs are uniquely positioned to give donors confidence in the organization's strengths, strategic vision and plans; those considering substantial investments in an organization's vision would also want to meet the individual who will ensure the diligent implementation of the proposed vision, which may also include board members.

CEO and board involvement demonstrate respect to those who are or would be the organization's staunchest allies, and significant donors are accustomed to having access to and interaction with an organization's top leaders. Thus, board and CEO involvement are essential in securing transformational gifts.

Presenting a Unified Front—Internally

The symbolic and tactical importance of the CEO in prioritizing philanthropy within the organization cannot be overstated, since no other organizational leader has the stature and relationships to single-handedly deploy the organization to advance it. The CEO's verbal support, physical presence and active modeling signals that philanthropy is important, elevates it on the agenda, sets expectations, unleashes resources and builds momentum with advocates.

With backing of the board, other ways CEOs can enhance philanthropy include:

- *Ensuring strategic alignment*. The CEO makes sure charitable dollars are directed to the organization's highest priorities

rather than being squandered on optional or low-value projects and can facilitate access to information about multi-year objectives, the supporting rationale, timeline, cost and more. This role fosters alignment with philanthropy by including the chief philanthropy officer in key strategy conversations, both to hear the dialogue and to provide perspective on the likelihood of donor support for an initiative. The CEO also collaborates with the foundation board to ensure a shared vision for the role of philanthropy in enabling future plans.

- *Leveraging allies*. The CEO has relationship equity to seek the active involvement of board members, clinicians and other senior executive allies as connectors, advocates and influencers. This role also can encourage physicians to champion philanthropy by sharing the clinical rationale for strategic projects and by enabling patients to express gratitude for care in a way that respects, affirms and enriches the patient experience.

- *Making adequate investments*. The CEO can ensure fund development is recognized as a revenue center rather than a cost center and can advocate for investment in the program consistent with the level of financial opportunity that exists. The CEO may sometimes also support expansion of budget and staff resources to build or expand the program, even when cuts are required in the organization's operational

budget since dollars invested in philanthropy can be multiplied and returned.

- *Positioning for credibility.* CEO support is pivotal in positioning the fund development function as credible and strategic. Key actions in doing this include engaging the chief philanthropy officer on the executive team to gain access to both information and internal allies. A strong working relationship between the two, based on mutual respect, regularly

scheduled interactions and open communication, also enables effective collaboration.

Ultimately, CEO engagement and board support—both inside and outside the hospital or healthcare facility—can enable philanthropy to flourish, and it is critical to optimizing fund development efforts. ▲

Betsy Chapin Taylor, FAHP, is CEO of Accordant (betsy@accordanthealth.com), Ponte Vedra Beach, Fla., and an ACHE Member.

A CEO's Perspective by Kimberly A. Russel, FACHE, CEO, Russel Advisors

The highlight of my healthcare executive career was serving as CEO of a community hospital, followed by service as CEO of a regional health system—totaling 25 years. A CEO's days (and nights) are filled with immense challenges and high stress levels, but interacting with philanthropic donors can be an uplifting, energizing and impactful aspect of the position.

For CEOs who may be reluctant to become deeply engaged in philanthropy, remember that philanthropy is based upon relationship-building. Most CEOs have a successful history of relationship-building with internal staff, physicians and community organizations. Extending the CEO's relationship-building skills to include current and potential donors is a natural continuation of the CEO's talents.

CEOs may be concerned about time demands. Sharing time with donors is a win-win; the organization will ultimately benefit, and the CEO can focus on the positive stories—along with current needs and future dreams—with friendly advocates. Consider these scenarios:

- Meeting with a family around their kitchen table to relate the importance of their deceased parent's past work as a pioneering physician at the hospital while sharing opportunities to continue their relative's impact.

- After an inpatient experience, developing an ongoing relationship with a local business leader with an interest in supporting workforce development.

Intentionally allocating CEO time to philanthropy will support mission-critical work and move the strategic plan further and faster. In my opinion, spending time with those who financially support the organization's initiatives is personally gratifying. Interacting with current and potential donors should be a bright spot in the CEO's crowded calendar.

Ensuring That Telehealth Equals Quality Care

Jonathan B. Perlin, MD, PhD, FACMI

As virtual care increases, a focus on safety and quality remains imperative.

For reasons of necessity during the COVID-19 pandemic, healthcare quickly turned to telehealth. This mode of care increased 154% during the early stages of the pandemic and rapidly accelerated to levels 38 times higher than in 2019. Today, the uses of telehealth encompass phone and video consultations, mobile health tools, text messaging portals, remote patient monitoring, tele-diagnostics for imaging and pathology, and more.

Widespread expansion of telehealth was enabled by the Centers for Medicare & Medicaid Services programs, as well as by commercial insurance companies when they broadened payment options and expanded coverage for telehealth services during the pandemic. Many telehealth-specific payment programs have been extended, allowing Medicare patients to continue to receive telehealth services in their homes by eligible Medicare providers.

Quality and Safety Considerations
As might be expected, with the expansion of telehealth comes concerns about assuring the quality and safety of care. While virtual care provides a novel way for patients and families to interact with clinicians, a reasonable expectation is that it must still meet the same quality and safety expectations as more traditional care settings.

Six aims or domains of healthcare quality were articulated by the Institute of Medicine, now the National Academy of Medicine, in 2001, and those dimensions still hold up today as a framework for assessing healthcare performance. Sometimes referred to as "STEEEP," the components include:

- **S**afety: Avoiding harm to patients from the care intended to help them.
- **T**imeliness: Reducing waits and even harmful delays for both those who receive and those who give care.
- **E**ffectiveness: Providing services based on scientific evidence for all who can benefit and refraining from providing unnecessary services to those not likely to benefit.
- **E**fficiency: Avoiding the waste of equipment and supplies, and patient, family and societal resources.
- **E**quity: Providing care that optimizes outcomes through sensitivity to the patient's identity and personal characteristics.
- **P**atient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

Researchers have found the IOM/NAM framework applicable to telehealth in a variety of situations. For example, it is effective in evaluating the quality and delivery of telehealth services for behavioral health among both geriatric and disadvantaged youth populations.

Quality researchers from the Mayo Clinic also developed a model for the performance evaluation of virtual care. With input from the American Medical Association, the Institute for Healthcare Improvement and the National Quality Forum, the model includes four domains to assess performance:

1. Economic: Demonstrating cost-effectiveness in providing quality care.
2. Experiential: Providing a positive experience for caregivers as well as for patients and their families.
3. Function: Working as intended in supporting care needs.
4. Equity: Being available in ways that prevent disparities in access or outcome.

Both the IOM/NAM domains and the Mayo evaluation framework suggest that quality of care be assessed based on the care being delivered and the condition being treated rather than on the modality used to deliver care. In other words, just as quality attributes must be present in traditional in-person interactions, they must also exist in virtual care encounters. Quality fundamentally must be judged based on fulfilling the clinical need and meeting the experiential expectations of patients and clinicians alike.

The Joint Commission's Focus
Beyond its founding mission for assuring safety, The Joint

Official Notice

for the 2024—2025 Council of Regents Elections

This official notice serves as the beginning of the election process to select new Regents to serve on the American College of Healthcare Executives' Council of Regents, the legislative body that represents ACHE's 49,000 members. Service as a Regent is a unique opportunity to exercise your leadership ability, share innovative ideas and support the mission of ACHE.

All Fellows who wish to run for election must submit an electronic letter of intent to elections@ache.org by Sept. 13, 2024. If you submit your letter of intent and you haven't received confirmation by Sept. 16, 2024, contact Nate Muckley at nmuckley@ache.org.

Please visit **ache.org/RegentElection** for more details.

Please note:

- To be an eligible Regent candidate, Fellows must work and reside in the Regent area they would represent.
- Elected Regents will serve a three-year term on the Council of Regents beginning at the close of the March 2025 Council of Regents meeting during ACHE's Congress on Healthcare Leadership.

For additional information about Regent responsibilities and eligibility, please contact Jennifer L. Connelly, FACHE, CAE, at (312) 424-9320 or jconnelly@ache.org.

ELECTIONS WILL BE HELD IN THE FOLLOWING JURISDICTIONS:

Air Force
Alaska
Arkansas
California—Northern
  & Central
Connecticut
Florida—Eastern
Illinois—Metropolitan
  Chicago
Indiana
Iowa
Kentucky
Maine
Missouri
New York—Metropolitan
  New York
South Dakota
Texas—Central & South
Veterans Affairs
West Virginia & Western
  Virginia

Commission is committed to advancing evidence-based, efficient, equitable and compassionate healthcare. While our focus has historically centered on the physical environment of care, ranging from hospital to home, our commitment is similar for telehealth and other remote services.

While telehealth has the potential to make care more accessible, and thus more equitable, especially for patients in rural communities, it also has the potential to exacerbate the "digital divide." For example, access may be challenging for those who are less tech-savvy, lack reliable broadband internet, or do have internet services but not a practical, in-home Wi-Fi network.

The U.S. Department of Health and Human Services provides several recommendations to help healthcare organizations make telehealth more accessible to all patients, including making training materials available for both patients and care providers. For patients, materials are available in multiple languages and are heavily illustrated for those with lower reading proficiency. Similarly, numerous bills are in Congress that build on commitments to make broadband available across rural parts of the United States.

Telehealth also plays a significant role in environmental sustainability. The healthcare industry accounts for nearly 9% of the nation's carbon emissions, and telehealth can help reduce healthcare's carbon footprint. Studies have measured fewer greenhouse gas emissions through telehealth due to reduced patient and staff travel, waste production and use of consumable materials.

Protecting patient privacy within any care delivery setting is a foundational element of a strong data use policy. This especially holds true during remote patient monitoring when large amounts of data are transmitted and potentially collected. It is critical that data remain private and secure through de-identification, data controls and limits on use beyond the immediate provision of care.

New Telehealth Accreditation Program
As telehealth continues to become a more prominent and consistent mode of care, The Joint Commission identified the need for updated, streamlined telehealth standards. By

convening telehealth experts, patient advocates and professional caregivers, we recently established requirements that provide guiding principles for healthcare organizations to deliver safe, high-quality care using a telehealth platform. They also constitute our assessment framework and include the same quality and performance expectations as traditional, physical care settings.

The Joint Commission's new Telehealth Accreditation Program, effective July 1, 2024, is for healthcare organizations that provide diagnostic evaluation, treatment and other services via telehealth. Dedicated telehealth providers, as well as hospitals, ambulatory and behavioral healthcare organizations with written agreements in place to provide care, treatment and services via telehealth to another organization's patients have the option to apply for the accreditation.

The accreditation program's requirements contain standards similar to other Joint Commission accreditation programs, such as requirements for information management, leadership, medication management, patient identification, documentation, and credentialing and privileging.

Requirements specific to the Telehealth Accreditation Program include:

- Streamlined emergency management requirements addressing care and clinical support remotely.

- New standards for telehealth provider education and patient education regarding the use of telehealth platforms and devices.
- New standards focusing on telehealth equipment, devices and connectivity.

Patients and families expect that all healthcare organizations have the structures and process in place to reduce risk and assure the best possible outcomes. We know our goal is shared by all patients and their loved ones that care is always safe, equitable, efficient, effective and compassionate. ▲

Jonathan B. Perlin, MD, PhD, FACMI, is president and CEO, The Joint Commission and Joint Commission International, Oakbrook Terrace, Ill.

Putting the 'Community' in Community Hospital

Jian Q. Zhang, DNP, NEA-BC, FAAN

Chinese Hospital intensifies its fundraising and a robust array of partnerships.

Located in San Francisco's legendary Chinatown neighborhood, the century-old Chinese Hospital faces both the unique financial and demographic challenges of serving its primarily Chinese patients as well as the same hurdles as all hospitals, especially independent ones in underserved areas. These challenges include physician and overall workforce shortages and labor cost increases stemming from the impacts of the COVID-19 pandemic.

The specific challenges of serving the hospital's patient population stem from the need to provide linguistically and culturally competent care. Workforce shortages are even tougher to reverse when bilingual physicians and other staff are needed.

As a small community hospital, Chinese Hospital has limited resources and needs to garner support from government and the community. That includes forming partnerships with entities such as the city's Department of Public Health and UCSF Health.

Founded in 1925 with roots in a medicinal dispensary that dates to 1899, Chinese Hospital was once the only place Chinese American patients in the community could seek care. As the only independent hospital remaining in San Francisco, a city that is about 23% Chinese and 37% Asian American overall, it remains a pillar of both the area's healthcare services and the community in general.

With a two-building, 88-bed acute care hospital and five outpatient clinics in San Francisco and northern San Mateo County, the hospital offers a blend of Eastern and Western medicine. More than 90% of patients are Chinese and many others are Asian Americans; the percentage of Chinese is higher at the main hospital campus than the clinics, given the location.

Challenges—Before and After the Pandemic

The hospital has plenty of hurdles to surmount, and the pandemic brought unprecedented challenges. The suspension of elective procedures, which are a vital source of revenue, resulted in a significant financial strain to the organization. Simultaneously, the hospital faced increased costs associated with personal protective equipment, additional staffing for COVID-19 response and the

implementation of new safety protocols. Labor shortages were exacerbated as healthcare workers fell ill or faced burnout, and the costs of retaining and hiring staff rose sharply.

The pandemic also brought a surge in anti-Asian hate crimes, adding another layer of difficulty for staff and patients. Many community members faced discrimination and violence, making them hesitant to seek medical care or leave their homes. Chinese Hospital responded by increasing security measures and working with local authorities to ensure the safety of patients and staff. The hospital also provided resources and support for those affected by these hate crimes, reinforcing our commitment to being a safe haven for the community.

Significant financial challenges during the past two years resulted in the need to obtain loans from various sources, such as California's distressed hospital fund. This is partly due to the patient population comprised of Chinese-speaking seniors on fixed incomes, with 80% relying on combination of federal Medicare and state Medi-Cal insurance.

The reimbursement rates for these programs are not the same as private health insurance—they often do not cover hospital costs. Due to an obscure federal rule, Chinese Hospital receives an even lower rate than others

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serving predominantly lower-income patients. Change in Medicare disproportionate share hospital policies in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 permanently imposed a 12% DSH payment adjustment cap for urban hospitals with fewer than 100 beds. Eliminating this adjustment cap of 12% would provide $550,000 in additional reimbursement dollars annually that would go directly back to our patient services as well as create new and improved existing patient service lines.

Labor shortages and costs have been significantly worse since COVID-19 due to inflation, as they are in so many other fields. According to the California Hospital Association, labor costs for hospitals and other healthcare providers have risen 15%, while pharmaceutical costs are up 41% in the state compared to pre-pandemic. Chinese Hospital's figures are, unfortunately, similar.

The specific challenges of serving the hospital's patient population stem from the need to provide linguistically and culturally competent care. Workforce shortages are even tougher to reverse when bilingual physicians and other staff are needed, including chaplains who can address the various religious backgrounds of our patients. Culturally competent care also requires bridging Western and Eastern medicine, including the latter's focus on holistic care and providing services like acupuncture and herbal treatments.

Chinese Hospital also provides culturally relevant health-related education and disease management, such as how to prevent or manage diabetes within the context of Chinese diets, given the predominance of rice and other carbohydrate-heavy foods. Cultural competence extends to issues such as knowing what patients like to eat when they are ill: soups that have been boiled for hours are considered to be very healing, while sandwiches and salads are not. Yet it is necessary to prepare the latter for non-Chinese patients. This has required a costly expansion of the hospital's kitchen to retain its California Department of Public Health license.

Lastly, Chinese Hospital continues to develop protections against discrimination in healthcare, ensuring individuals, including those with disabilities, receive equitable access to care. Chinese Hospital aims to improve in four areas: web and mobile accessibility to health programs and activities; medical equipment accessibility; programs that meet the needs of individuals with disabilities; and communication methods for patients with hearing, vision and/or speech disabilities. These efforts also generate costly expenses.

Solutions to Date—and to Come
Like other institutions serving Bay Area residents on fixed incomes, Chinese Hospital has surmounted its patient care losses thanks to revenue from a combination of ceaseless fundraising and the provision of ancillary services.

The capitation payments received from our own health plan and others—especially during the stay-at-home phase of the pandemic, when elective procedures were all postponed—provided much-needed income for our operation.

Our partnerships also have helped us survive. Chinese Hospital has partnered with San Francisco's Department of Public Health to create a hospital-based skilled nursing facility/sub-acute unit, a type of facility the city has lacked. Over the past two years, $10 million in state funding was secured to help Chinese Hospital establish the unit. The partnership with UCSF Health enabled the hospital to expand access to much-needed complex specialty care for more patients such as the primary stroke center.

For independent community hospitals like Chinese Hospital, mainly serving low-income Medicare and Medicaid patients, government subsidies and community support are crucial to sustain and continue to provide culturally and linguistically appropriate care.

As part of that, if the Medicare DSH cap is removed, it will ensure community hospitals are fairly reimbursed for the critical services they provide. The cost of making this change for all the urban hospitals affected would be less than $10 million annually, which represents a fraction of the Centers for Medicare & Medicaid Services budget.

The additional reimbursement would pay for itself over time by helping us improve the overall health of the patients we serve and, likewise, helping other hospitals to do the same in their communities. The removal of the DSH cap will eliminate the unintended discriminatory and unfair CMS reimbursement policy on small urban community hospitals, which mostly serve disadvantaged populations and promote health equity and access. ▲

Jian Q. Zhang is CEO of Chinese Hospital in San Francisco and an ACHE Member (JianZ@chasf.org).

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 2023–2024 committee year, the Ethics Committee considered 18 issues involving ACHE members. Three of these cases continue to be under investigation in 2024.

The Ethics Committee is also responsible for conducting annual evaluations of ACHE's *Code of Ethics* and Grievance Procedure and for recommending updates.

Ethics Committee members are ACHE Fellows who are appointed by the Board of Governors; they serve confidentially, with the exception of the committee chair, whose name is made public. The *Code of Ethics*, Ethical Policy Statements and other ethics resources are available at **ache.org/Ethics**. The Ethics Self-Assessment, which allows you to evaluate your ethics-related leadership and actions, how to address individual or team development needs, can be found here: **ache.org/EthicsSelfAssessment**. A printed version of the self-assessment is available in this issue.

2024 Fund for Healthcare Leadership Scholars Selected

Seventy-eight applicants have been selected to receive scholarships supported by the Fund for Healthcare Leadership. The number of award recipients are as follows: Thomas C. Dolan Diversity in Executive Leadership Program (13), the Career Accelerator Program (50) and the Executive Program (15).

Over 300 high-caliber executives applied for these prestigious national programs, which provide education, mentoring and networking experiences to prepare underrepresented leaders for higher-level positions in hospitals, health systems and other settings.

Named in honor of Thomas C. Dolan, PhD, FACHE, CAE, who served as president/CEO of ACHE from 1991 to 2013, this year's program will consist of three in-person sessions and multiple virtual sessions, including live and recorded webinars, coaching and self-study materials.

The Career Accelerator Program supports mid-careerists in their professional advancement and is exclusively virtual, consisting of 14 live sessions. Scholars are empowered through a structured curriculum and activities that cultivate strong leadership presence, build critical leadership skills and expand one's capacity to navigate career opportunities.

The Executive Program features three in-person modules with intermittent virtual education between sessions, each featuring resources and discussion that deliver unique insights on topics relevant to specific challenges healthcare leaders face. This immersive five-month program provides customized coaching and offers approaches to satisfy a variety of learning styles.

All three scholarships are wholly endowed by the Fund for Healthcare Leadership. ACHE is also on a bold mission to raise $1 million for the Fund for Healthcare Leadership by March 2025. Visit **ache.org/Fund** to learn more about the 2024 scholars, programs and the $1 million campaign.

In Memoriam

ACHE regretfully reports the deaths of the following ACHE members as reported by the Department of Executive Engagement:

Patricia M. Morris
Queens Village, N.Y.

Carol L. Paul, LFACHE
Maplewood, N.J.

Timothy H. Reanick
Jacksonville, Fla.

Philip S. Rice
Lake Worth Beach, Fla.

Vanda L. Scott, EdD, FACHE
Knoxville, Tenn.

American Hospital Association Recognizes ACHE Members

During the AHA's 2024 Annual Membership Meeting in April, two Fellows and a Life Fellow of the American College of Healthcare Executives were among those who received awards for their service to the healthcare field and for innovative approaches to providing care.

Distinguished Service Award

Brian A. Gragnolati, FACHE, president and CEO, Atlantic Health System, Morristown, N.J., was awarded the AHA's 2024 Distinguished Service Award. The award is the AHA's highest honor, given to recognize significant lifetime contributions to the nation's healthcare institutions.

Board of Trustees Award

Steven Summer, LFACHE, former president and CEO of the Colorado Hospital Association and the West Virginia Hospital Association, and president and CEO of The Healthcare Institute, received AHA's 2024 Board of Trustees Award. The award is presented to individuals or groups who have made substantial and noteworthy contributions to the work of the AHA on behalf of the hospital field.

Award for Excellence

Col. Craig Keyes, FACHE, chief of staff and deputy director, Defense Health Network—National Capital Region, Bethesda, Md., received the AHA's 2024 Award for Excellence. The award recognizes uniformed and nonuniformed federal healthcare leaders who have distinguished themselves through singularly significant or innovative achievements and leadership that have contributed substantially to the mission of the federal health system.

Member-Led Organizations Receive Gallup Exceptional Workplace Award

Three ACHE member-led organizations received the 2024 Gallup Exceptional Workplace Award, which recognizes employee engagement. They are:

- Children's Health of Texas, Dallas, led by Christopher J. Durovich, FACHE, president/CEO (three-time winner).

- Exact Sciences Corp., Madison, Wis., led by Kevin Conroy, president and CEO.

- Hendrick Health, Abilene, Texas, led by Brad D. Holland, FACHE, president and CEO (18-time winner).

A total of 57 organizations in a variety of industries received the award.

ACHE Announces Two Retirements

Peter A. Kimball, senior data analyst, Research Department, retired in May after 34 years of service. Peter joined ACHE in 1990 as a data analyst/statistician and was promoted to senior data analyst/statistician in 2016. He was recognized as an Alton E. Pickert award recipient in 1997. In his role, Peter has long been the keeper, verifier and interpreter of ACHE data. His unwavering commitment to data integrity has left an indelible mark on the organization. Peter has been an integral part of the ACHE team, and his transition will mark the beginning of a well-deserved new chapter in his life.

Joseph R. Pixler, senior editor, Health Administration Press, retired after nearly eight years of service. Joe has made tremendous contributions to HAP, the Learn team and ACHE as a whole. In his time at ACHE, he has spearheaded the *Journal of Healthcare Management* and *Frontiers of Health Services Management*, leading them to increased quality and visibility among our members and beyond. In addition, he has edited numerous HAP books and contributed to many other efforts, including Congress on Healthcare Leadership presentation review and the Learn Team Retreat. Joe has had a long, impactful career in journalism, writing and editing, and his contributions will be missed.

Postgraduate Fellow and Diversity Intern Announced

Sherie Yoon has been selected as the 2024–2025 Stuart A. Westbury Jr. Postgraduate Fellow. Sherie graduated in 2024 with a master's degree in healthcare administration from the University of the Incarnate Word. She has worked most recently as a graduate intern for UT Health in San Antonio. ACHE established the fellowship in 1991 to further postgraduate education in healthcare and professional society management.

Oladimeji Taiwo has been selected as the ACHE Diversity Intern through the Institute for Diversity and Health Equity's Summer Enrichment Program. Taiwo is pursuing a Master of Public Health from Western Illinois University and expects to graduate in May 2025.

Both the yearlong fellowship and the three-month internship offer exposure to a broad range of association management issues through interactions with senior-level executives and rotations through each of ACHE's departments.

Do you know how influential you are?

In 2023, more than 2,100 healthcare leaders joined ACHE or became board certified in healthcare management as an ACHE Fellow (FACHE®) because of encouragement from members like you. Thank you.

Make a difference by sharing the value of ACHE
Each time you refer a new Member, or a current Member advances to Fellow, you earn rewards through our Leader-to-Leader Rewards Program.

To learn more, visit **ache.org/L2L**

American College of HealthcareExecutives®

The American College of Healthcare Executives congratulates members who recently received awards recognizing their contribution to healthcare leadership.

Chad Adams, FACHE, associate director for operations (COO), North Florida/South Georgia VHS, Gainesville, Fla., received the Commitment to Service Award from the Regent for Veterans Affairs.

Meredith A. Arensman, MD, chief of staff, Veterans Health Administration, Washington, D.C., received the Early Careerist Regent Award from the Regent for Veterans Affairs.

Jenny J. Breunig, FACHE, COO, Crozer Health System, Chester, Pa., received the Senior-Level Regent Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Kimber A. Brown, consultant/business process engineer, HRS Consulting Inc., Weston, Fla., received the Outstanding Service Award from the Regent for Pennsylvania.

Larissa Chia, Yale University, New Haven, Conn., received the Student Award from the Regent for Connecticut.

Dawn Davison, FACHE, director, Operations, Rochester (N.Y.) Regional Health, received the Early Careerist Regent Award from the Regent for New York—Northern and Western.

Michael S. Eppehimer, FACHE, founder/CEO, ThreefoldYes LLC, Wilmington, Del., received the Senior-Level Regent Award from the Regent for Delaware.

Froy Garza, CEO/executive director, El Paso (Texas) VA Health Care System, received the 2024 Graduate Health Administrative Training Program Preceptor of the Year Award from the Regent for Veterans Affairs.

Emese S. Hand, administrative fellow, Atrium Health, Charlotte, N.C., received the DEI Champion Award from the Regent for North Carolina.

Olugbemiga E. Jegede, MD, FACHE, vice president, Clinical Care & Health Equity, Cone Health, Greensboro, N.C., received the DEI Champion Award from the Regent for North Carolina.

Tiffany C. Jennings, EdD, FACHE, U.S. Department of Veterans Affairs, received the Regent Advisory Council Excellence Award from the Regent for Veterans Affairs.

Teray Johnson, PhD, director, Data Automation and Transformation, Lifepoint Health, Brentwood, Tenn., received the Early Careerist Regent Award from the Regent for Pennsylvania—Southeast & Southern New Jersey.

Charles D. Lovell Jr., FACHE, CEO, Barbourville (Ky.) ARH Hospital, received the Senior-Level Regent Award from the Regent for Kentucky.

Heather L. Lynch, pharmacy operations manager, Singing River Health System, Pascagoula, Miss., received the Early Careerist Regent Award from the Regent for Mississippi.

Ashley J. Manifold received the Early Careerist Regent Award from the Regent for North Carolina.

Andrew McCart, PhD, FACHE, associate program director, University of Louisville (Ky.), received the Early Careerist Regent Award from the Regent for Kentucky.

Michael A. Novak, FACHE, vice president/COO, Montefiore Nyack (N.Y.) Hospital, received the

Want to submit?

Send your "Member Accolades" submission to he-editor@ache.org. Due to production lead times, entries must be received by Aug. 1 to be considered for the Nov/Dec issue.

Senior-Level Regent Award from the Regent for Connecticut.

Sarah Paparella, licensed nursing home administrator, Evergreen Commons Rehabilitation & Nursing Center, East Greenbush, N.Y., received the Early Careerist Regent Award from the Regent for New York—Northern and Western.

Ana-Elis Perry, FACHE, associate vice president, Operations, UNC Health, Chapel Hill, N.C., received the Senior-Level Regent Award from the Regent for North Carolina.

Kenneth P. Piazza, FACHE, assistant director, VA Finger Lakes Healthcare System, Honeoye Falls, N.Y., received the Regent Award from the Regent for New York—Northern and Western.

Joshua W. Smith, manager, Rehabilitation, Bayhealth Medical Center, Dover, Del., received the Early Careerist Regent Award from the Regent for Delaware.

Savannah Stallings received the Early Careerist Regent Award from the Regent for North Carolina.

Katina D. Stone-Jones, FACHE, chief, Quality and Patient Safety, Dayton (Ohio) VA Medical Center, received the High Reliability Organization Award from the Regent for Veterans Affairs.

Gwyndolan L. Swain, DHA, founding program director/full professor/ health administration, Belmont Abbey College, Belmont, N.C., received the Faculty Leader Award from the Regent for North Carolina.

Ezela Tagliente, senior managing consultant, Berkeley Research Group, Emeryville, Calif., received the Early Careerist Regent Award from the Regent for New York—Northern and Western.

LCDR Raben B. Talvo, FACHE, program manager, Defense Health Agency, Falls Church, Va., received the Early Careerist Regent Award from the Regent for Navy.

David J. VanMeter, FACHE, COO, James A. Haley Veterans Hospital, Tampa, Fla., received the Senior-Level Regent Award from the Regent for Veterans Affairs.

HMC Jeremy Velasquez, FACHE, senior medical department representative, received the Enlisted Healthcare Executive Award from the Regent for Navy.

George Velez, DHA, FACHE, medical center director/CEO, VA Healthcare System of the Ozarks, Fayetteville, Ark., received the Leadership Development Award from the Regent for Veterans Affairs.

Julie L. Vigil, FACHE, branch chief, Connecticut Department of Public Health, Hartford, Conn., received the Early Careerist Regent Award from the Regent for Connecticut.

CDR Andrew J. Weiss, FACHE, deputy director/N12, Bureau of Medicine & Surgery, Falls Church, Va., received the Senior-Level Regent Award from the Regent for Navy.

Growth and Strategy

HLNY, Oregon Chapter of ACHE set themselves up for success.

Healthcare Leaders of New York
The chapter forged new ground with many firsts earlier this year. Several initiatives were planned and implemented by the Membership Committee to retain, grow and more deeply engage with HLNY members.

In February, HLNY drew nearly 100 people to its first virtual town hall, which detailed ACHE membership opportunities and featured interactive testimonials. They also hed a Q&A that inspired nonmembers to join and existing members to re-engage with the chapter.

Following the town hall, the chapter sent a membership survey to members and nonmembers asking them to share their experiences and express their ideas for improving the chapter's offerings. The survey was designed to gain insights on more specific demographics, including identity descriptions, job roles and types of employers, and it explored preferences for engaging with HLNY and potential barriers to participation.

Due to a low response rate, the Membership Committee extended the survey deadline and offered an opportunity to enter a raffle with prizes, including a HLNY wine tumbler, a backpack and a grand prize of a free ticket to an upcoming event. With a random winner drawn and announced weekly to generate interest, participation increased by over 400%, with a total of 169 respondents when the survey was closed.

In preparation for this year's membership drop of those who have not paid their chapter dues, the Membership Committee led a communication campaign in partnership with the Marketing Committee via email and social media. In a multi-part series, the campaign targeted members with unpaid dues for 2024 with reminders to renew membership that listed member benefits. Additional visual graphics with similar messaging were posted to a broader audience on LinkedIn.

Part of the campaign included a specific message to student members, encouraging them to upgrade to full Member status. To supplement the campaign, four individual testimonials were shared on LinkedIn, spotlighting student members, past presidents and board members that included quotes of their personal "whys" (titled "My HLNY") for joining, continually engaging and giving back to the chapter. Click rates and engagement metrics for the campaign are being reviewed for impact.

The average annual membership decline for the chapter has historically been 22%, but the campaigns and engagement in the first quarter of this year reduced the drop-off rate to only 16% for 2024, a 10-point improvement from the previous year.

Oregon Chapter of ACHE
The chapter has been taking new steps to invigorate and engage its members across Oregon. When Valdez G. Bravo, FACHE, then the chapter's president-elect, attended ACHE's Chapter Leaders Conference in 2022, the best practices and information sharing he heard there about meeting the full value proposition of chapter members inspired him to take what he learned back to his chapter. So, he drafted a 10-point strategic plan that he presented to the chapter board at a strategic planning retreat. After reviewing the various metrics, the board identified goals and subgoals to assess progress and celebrate success.

"I am so excited about the energy and innovation that the members of the Oregon Chapter of ACHE are bringing to the table," said Bravo. "Democratizing our board, committees and chapter planning has yielded such great benefits for our membership!"

Next, the board reinvigorated the Planning & Education Committee by giving members an opportunity to get involved and plan programming. The chapter also created two new committees: a Communications

Committee to market education events and provide updates to chapter members, and a Membership Committee to plan and offer networking events, assist members with advancing to Fellow and ensure the chapter is meeting the value proposition for its members.

Another exciting change for the chapter was holding open elections for the board positions. Traditionally, new board members had been referred and recruited to board service by existing board members, and during the COVID-19 pandemic, the board had not regularly filled those vacated seats. Last fall, Bravo solicited interest from the chapter and received a dozen candidates for the secretary/treasurer role and three board member positions. The election had a turnout rate of 24%, and newly elected board members were revealed and celebrated at the Oregon ACHE Fall Conference. In the spring, the chapter held an open election for president in accordance with the chapter bylaws, with the president-elect named at this year's Spring Conference.

Additionally, Oregon has a new Regent, Jane J. Russell, PharmD, FACHE, who began her three-year term as Regent in March. Russell brings deep experience from her past work for other chapters, which will benefit the members in Oregon. ▲

To find your chapter, search the chapter directory. To discuss your ideas for chapters, contact Stacey A. Kidd, CAE, director, Chapter Relations, Department of Executive Engagement, at (312) 424-9323 or skidd@ache.org.

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**. 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.	○	○	○	○	○
I place community/patient benefit over my personal gain.	○	○	○	○	○
I strive to be a role model for ethical behavior.	○	○	○	○	○
I work to ensure that decisions about access to care are based primarily on medical necessity, not only on the ability to pay.	○	○	○	○	○
My statements and actions are consistent with professional ethical standards, including the ACHE *Code of Ethics*.	○	○	○	○	○
My statements and actions are honest, even when circumstances would allow me to confuse the issues.	○	○	○	○	○
I advocate ethical decision-making by the board, management team and medical staff.	○	○	○	○	○
I use an ethical approach to conflict resolution.	○	○	○	○	○
I initiate and encourage discussion of the ethical aspects of management/financial issues.	○	○	○	○	○
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).	○	○	○	○	○
I promptly and candidly explain to internal and external stakeholders negative economic trends and encourage appropriate action.	○	○	○	○	○
I use my authority solely to fulfill my responsibilities and not for self-interest or to further the interests of family, friends or associates.	○	○	○	○	○
When an ethical conflict confronts my organization or me, I am successful in finding an effective resolution process and ensuring it is followed.	○	○	○	○	○
I demonstrate respect for my colleagues, superiors and staff.	○	○	○	○	○
I demonstrate my organization's vision, mission and value statements in my actions.	○	○	○	○	○
I make timely decisions rather than delaying them to avoid difficult or politically risky choices.	○	○	○	○	○

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

II. RELATIONSHIPS

Community

	Almost Never	Occasionally	Usually	Always	Not Applicable
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

	Almost Never	Occasionally	Usually	Always	Not Applicable
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.	○	○	○	○	○
I protect patients' rights to autonomy through access to full, accurate information about their illnesses, treatment options, and related costs and benefits.	○	○	○	○	○
I promote a patient's right to privacy, including medical record confidentiality, and do not tolerate breaches of this confidentiality.	○	○	○	○	○
I am committed to eliminating harm in the workplace.	○	○	○	○	○
I am committed to helping address affordability challenges in healthcare.	○	○	○	○	○

Board

	Almost Never	Occasionally	Usually	Always	Not Applicable
I have a routine system in place for board members to make full disclosure and reveal potential conflicts of interest.	○	○	○	○	○
I ensure that reports to the board, my own or others', appropriately convey risks of decisions or proposed projects.	○	○	○	○	○
I work to keep the board focused on ethical issues of importance to the organization, community and other stakeholders.	○	○	○	○	○
I keep the board appropriately informed of patient safety and quality indicators.	○	○	○	○	○
I promote board discussion of resource allocation issues, particularly those where organizational and community interests may appear to be incompatible.	○	○	○	○	○
I keep the board appropriately informed about issues of alleged financial malfeasance, clinical malpractice and potentially litigious situations involving employees.	○	○	○	○	○

Colleagues and Staff

	Almost Never	Occasionally	Usually	Always	Not Applicable
I foster discussions about ethical concerns when they arise.	○	○	○	○	○
I maintain confidences entrusted to me.	○	○	○	○	○
I demonstrate through personal actions and organizational policies zero tolerance for any form of staff harassment.	○	○	○	○	○

	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.	○	○	○	○	○
I fulfill the promises I make.	○	○	○	○	○
I am respectful of views different from mine.	○	○	○	○	○
I am respectful of individuals who differ from me in ethnicity, gender, education or job position.	○	○	○	○	○
I convey negative news promptly and openly, not allowing employees or others to be misled.	○	○	○	○	○
I expect and hold staff accountable for adherence to our organization's ethical standards (e.g., through performance reviews).	○	○	○	○	○
I demonstrate that incompetent supervision is not tolerated and make timely decisions regarding marginally performing managers.	○	○	○	○	○
I ensure adherence to ethics-related policies and practices affecting patients and staff.	○	○	○	○	○
I am sensitive to employees who have ethical concerns and facilitate resolution of these concerns.	○	○	○	○	○
I encourage the use of organizational mechanisms (e.g., an ethics committee or program) and other ethics resources to address ethical issues.	○	○	○	○	○
I act quickly and decisively when employees are not treated fairly in their relationships with other employees.	○	○	○	○	○
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.	○	○	○	○	○
I hold all staff and clinical/business partners accountable for compliance with professional standards, including ethical behavior.	○	○	○	○	○
I am sensitive to the stress of the healthcare workforce (including physicians and other clinicians), and take steps to address personal wellness and professional fulfillment, such as incorporating these issues in employee and physician satisfaction/engagement surveys.	○	○	○	○	○
I take steps to understand my workforce as it relates to safety, stress and burnout and consider the impact of those who are in positions of authority (including executives and physicians).	○	○	○	○	○

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

Gershon

Groah

Hickman

Oldehoff

Placensia

Santulli

Meghan Aldrich, DNP, to president, Sisters of Charity Hospital and St. Joseph Campus, Cheektowaga, N.Y., from COO, Heritage Ministries, Gerry, N.Y.

Steve Altmiller to retirement from president/CEO, WVU Medicine Camden Clark Medical Center, Parkersburg, W.Va. ACHE thanks Steve for his years of service to the healthcare field.

Allen Bible, DPT, FACHE, to COO, Siskin Children's Institute, Chattanooga, Tenn., from president, Noon Health, Chattanooga, Tenn.

Jeremy Bradshaw to market president, Greater Salt Lake Market, CommonSpirit Health, Chicago, from CEO, St. Mark's Hospital, Salt Lake City.

Ann Marie Brooks, PhD, RN, FACHE, to interim dean, School of Nursing, Mount Saint Mary College, Newburgh, N.Y., from president, Mount Carmel College of Nursing, Columbus, Ohio.

Caroline F. Burris to CEO, Parkridge East Hospital, Chattanooga, Tenn., from COO/ethics and compliance officer, HCA Florida Ft. Walton-Destin Hospital.

Gina L. Calder, FACHE, to president, Central Region, Hartford (Conn.) HealthCare, from president, Barnes-Jewish St. Peters (Mo.) Hospital and Progress West Hospital, O'Fallon, Mo.

Steven L. Cardenas, FACHE, to senior vice president, Government Services, Healthcare IT Leaders, Alpharetta, Ga.

Jay deVenny, FACHE, to CEO, Medical City Dallas, from CEO Medical City Children's Hospital and Medical City Women's Hospital Dallas.

Blake Dye, LFACHE, to interim president, Indiana Hospital Association, Indianapolis.

Scott A. Edelman, CPA, to executive director, Burke Rehabilitation

Center, White Plains, N.Y., from interim executive director.

Frederika Ford to CEO, Recovery Centers of America Capital Region, Waldorf, Md., from CEO, Behavioral Institutes of America, Atlanta.

Howard J. Gershon, LFACHE, to retirement from founding principal, New Heights Group, Santa Fe, N.M. ACHE thanks Howard for his years of service to the healthcare field.

Bradley Goettl, DNP, FACHE, to chief clinical officer, The Emergency Nurses Association, Schaumburg, Ill., from director, Advanced Practice Provider Fellowships Programs, UT Southwestern Medical Center, Dallas.

Andrew Goldfrach, FACHE, to CEO, Arrowhead Regional Medical Center, Colton, Calif., from COO.

Want to submit?

Send your "On the Move" submission to he-editor@ache.org. Due to production lead times, entries must be received by Aug 1 to be considered for the Nov/Dec issue.

CORE CLINICAL PARTNERS

Will Gordon to CEO, Abbeville (S.C.) Area Medical Center, from vice president and chief administrative officer, Self Regional Healthcare, Greenwood, S.C.

Richard G. Greenhill, DHA, FACHE, to chief transformation officer, Quality Insights, Charleston W.Va., from director, Bachelor of Science in Healthcare Management and assistant professor, Texas Tech University Health Sciences Center, Lubbock, Texas.

Linda Groah to retirement from CEO, Association of Perioperative Registered Nurses. ACHE thanks Linda for her years of service to the healthcare field.

Ryan R. Hawkins, to president/CEO, Jessie Trice Health System, Miami, from COO, Jackson North Medical Center, North Miami Beach, Fla.

Sherie C. Hickman, FACHE, to retirement from CEO, Sutter Delta Medical Center, Antioch, Calif. ACHE thanks Sherie for her years of service to the healthcare field.

Robert "Bob" Honeycutt to president, CHRISTUS Santa Rosa Hospital–San Marcos (Texas), from CEO, Saint Mary's Regional Health System, Russellville, Ark.

Margaret M. Horvath, FACHE, to executive director, Providence Alaska Children's Hospital, from executive director, Alaska Health Alliance with Providence.

Blake Hubbard, FACHE, to CEO, Valley View Medical Center, Ft. Mohave, Ariz., from regional vice

president, Legent Health, San Antonio.

David Link to vice president, Operations, HCA Florida South Shore Hospital, Sun City, Fla., from ethics and compliance officer, St. Mark's Hospital, Millcreek, Utah.

Justin Lundbye, MD, FACHE, to president, Good Samaritan University Hospital, West Islip, N.Y., from CEO, Waterbury (Conn.) Health.

Julia Mason, DNP, RN, to CNO/senior vice president, Patient Care Services, Brigham and Women's Hospital, Boston, from CNO/senior vice president, Patient Care Services, The MetroHealth System, Cleveland.

Justina Oldehoff to COO, Colorado Blood Cancer Institute Medical Group, Denver, from senior director, DispatchHealth, Denver, and AdventHealth, Altamonte Springs, Fla.

Jonathan Plasencia, FACHE, to vice president, Operations, Core Clinical Partners, Atlanta.

Hong Potomski, FACHE, to market leader, Florida Blue, Pensacola, Fla., from senior director, Regional Business Development.

Michael J. Randall, FACHE, to vice president, Strategy and Business Development, Franciscan Health Olympia Fields (Ill.), from vice president, Medical Specialties, Duly Health and Care, Downers Grove, Ill.

Skyler Reed, FACHE, to CEO, Medical City Children's Hospital and Medical City Women's Hospital Dallas, from COO, Medical City Dallas.

Jody Reyes, FACHE, to COO, clinical enterprise, University of Iowa Health Care, Iowa City, from senior vice president/COO, Penn State Health Milton S. Hershey (Pa.) Medical Center.

Bert Roberson to CFO, U.S. Department of Veterans Affairs, West Consolidated Patient Accounts Center, Las Vegas, from clinic administrator, VA Southern Nevada Healthcare System, North Las Vegas.

Alejandro Romero to CEO, Las Palmas Medical Center, El Paso, Texas, from COO, Del Sol Medical Center, Trinity, Fla.

Anthony Saul, FACHE, to senior executive vice president/COO/CFO, Grady Health System, Atlanta, from CFO.

William P. Santulli, FACHE, to operating partner, Water Street Healthcare Partners, Chicago, from president, Advocate Health Midwest, Oak Brook, Ill.

David Schultz, FACHE, to president, Hospital Operations, Ardent Health, Nashville, Tenn., from president, New Mexico market.

Chris Sloan to executive vice president, Medical Operations, Loyal Source Government Services, Orlando, Fla., from COO Texas Vista Medical Center, San Antonio.

Thomas Snyder, RN, CLSSBB, FACHE, to principal, AddPrana LLC, Phoenix, from director, Quality, Banner Casa Grande (Ariz.); Banner Ironwood, Queen Creek, Ariz.; and Banner Goldfield, Apache Junction, Ariz., Medical Centers.

Shelly Soileau to CFO, Opelousas (La.) General Health System, from CFO, Savoy Medical Center, Mamou, La.

BG Bill A. Soliz, FACHE, to brigadier general, U.S. Army. Soliz is the first active-duty physician assistant to become a general, as well as the first Hispanic American non-physician general officer and commanding general in the Army Medical Department.

Justin Turner to COO, Rivers Health, Point Pleasant, W.Va., from COO, Highlands Appalachian Regional Healthcare Regional Medical Center, Prestonsburg, Ky.

Kevin A. Vest, FACHE, to network vice president, Cancer Clinical Programs, The University of Vermont Cancer Center and the UVM Health Network, Burlington, Vt., from vice president, Centers of Excellence, Smilow Cancer Hospital, Yale New Haven (Conn.) Health System.

Richelle Webb Dixon, FACHE, to senior vice president/chief administrative officer, University of Maryland Medical System, Baltimore, from senior vice president/COO, Froedtert Hospital, Milwaukee.

Matthew Whitley to COO, Erlanger Behavioral Health, Chattanooga, Tenn., from executive director, Storypoint Group, Naperville, Ill.

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