

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

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PAYERS AND PROVIDERS

Partnerships Lead to Success



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A close-up portrait of a Black man with a friendly smile, wearing a dark blue suit jacket, a light blue dress shirt, and a dark blue tie. The background is a soft, out-of-focus purple and blue gradient.

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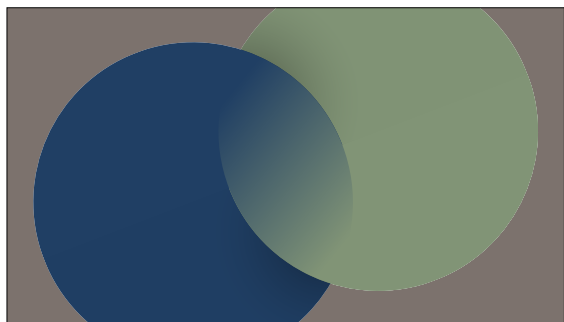
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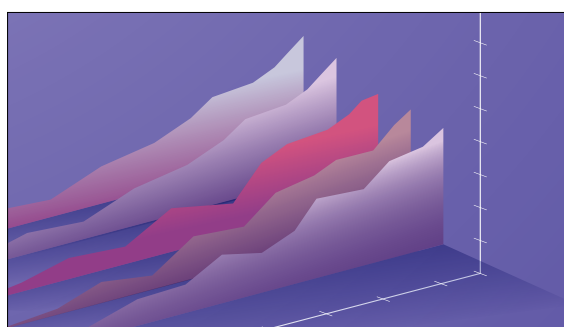
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The most effective partnership models vary, from collaborative contractual relationships to joint ventures and mergers. Irrespective of the market status or characteristics of these partnerships, health plans and providers are all seeking to drive and create value.

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Though underlying issues stemming from the pandemic will not soon be forgotten, forward-thinking leaders are already exploring financial opportunities to mitigate future scenarios that were once unanticipated, if not downright unimaginable.

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Fresh, Exclusive Content

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

Help for Ailing Community Hospitals

Even before the pandemic, economic sustainability was a challenge for community and rural hospitals, given the operational and financial issues they faced daily. The pandemic's impact has made it even tougher for many to remain fiscally sound. In this article, read how an operational action plan can provide long-term stability.

The Seven Phases of Authenticity Leadership and Building Trust

This web extra goes into more detail on the seven phases of authenticity leadership and building trust that is highlighted in the Careers column in this issue.



Recent Healthcare Executive Podcasts

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

Carson Dye, FACHE, president and CEO of Exceptional Leadership LLC, discusses the practical ways executives can form effective relationships with physicians and clinical leaders in the podcast "Enhanced Physician Engagement."

Nicole M. Cooper, DrPH, senior vice president, Corporate Affairs, UnitedHealth Group, talks about health equity from the payer's perspective in the podcast "Health Equity: Where Do We Go From Here?"

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Leading Your Financial Strategy

A shift in the financial winds that began before the pandemic has only accelerated because of the global health crisis. This circumstance has placed many leaders in the position of addressing the changes they're now facing month by month. Everything, from resource needs to staffing, is being affected.

Though each organization faces unique circumstances in this ever-evolving environment, you'll find innovative solutions in *Healthcare Executive's* two features that will help ensure your fiscal and operational success while maintaining patient satisfaction amid an uncertain future.

In our cover story, "Payers and Providers: Partnerships Lead to Success" (Page 8), you will read about how this dynamic is starting to change, as evidenced by an uptick in collaborative conversations, alliances and business arrangements between insurers and providers. "There are win-win opportunities in the marketplace right now if payers and providers can better organize themselves accordingly," says one expert.

The most effective partnership models vary, from collaborative contractual relationships intended to optimize value-based goals (i.e., improved quality, care access and cost management) to joint ventures and mergers aimed at launching enhanced health plan offerings and care delivery options (e.g., primary care access and digital health offerings). New payer-provider joint ventures are launching with increased frequency.

In the feature "Have You Future-Proofed Your Organization? Planning for Success—and Stability—Now and Down the Road" (Page 18), we explore financial opportunities to mitigate future scenarios that were once unanticipated, if not downright unimaginable.

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

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Deborah J. Bowen,
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Strategic Planning: Charting a Course

*Working together, we can make a difference
in advancing health.*

Embarking on a new strategic plan is an opportunity to amplify strengths and identify new opportunities. This moment is particularly important as we chart a course for our profession in a post-pandemic world. For ACHE, this means elevating what makes us unique as a leadership organization and forging new pathways to leverage our vision, mission and values: integrity, lifelong learning, leadership, and diversity and inclusion.

As Carrie Owen Plietz, FACHE, Chair of the ACHE Board of Governors and regional president, Northern California, Kaiser Permanente, noted during our strategic planning development process, we have much to be proud of in navigating one of the most challenging eras in our nearly 90-year history. Yet, we must evolve ACHE to meet our members' needs in an ever-changing landscape.

The Board's "deep dive" last year into ACHE's Strategic Plan considered perspectives both inside and outside the organization, seeking diverse input from thought leaders across the country from a variety of disciplines and settings. Our members, Regents and chapters also gave voice to the plan. The feedback provided a striking consensus on the near-term priorities for ACHE and our role to

support, advance and diversify the leadership workforce.

The Board articulated a set of ambitions, as stated below, to capture these priorities. Each ambition has added tactics and guidelines to leverage our roles as *catalyst*, *connector* and *trusted partner* during the next three years:

As a Catalyst, achieve our highest calling to advance health by leading through the lens of equity. To achieve this, ACHE will commit to leading for equity and safety. As always, we will look at new strategies that will advance equity and diversify our field. As a champion for safety, we will continue providing tools to help leaders achieve zero preventable harm, while also discovering new ways to amplify the importance of safety.

As a Connector, grow our professional community of leaders across the healthcare continuum by leveraging our partnerships with chapters and other organizations. We know our chapter network is the lifeblood of ACHE and vital to the execution of our mission. We will elevate our collaboration with chapters to deliver education, networking and other benefits in new and impactful ways. By embracing leaders across the care continuum, we

will grow our community, broaden our perspective and be more prepared to realize the full promise of health and well-being.

To expand our role and influence as a Trusted Partner to help leaders reach their highest potential to lead.

We are committed to deepening our engagement with members and the healthcare community through education, networking and career services that inspire and cultivate leaders to advance health. In doing so, we will provide unparalleled face-to-face and digital learning experiences. We will also ensure these resources help employers develop a strong, capable and resilient workforce.

Effective healthcare leadership requires a clear road map that empowers professionals to deliver safe and equitable care for patients and communities. Our Strategic Plan sets forth that road map, but the journey to advance ourselves, our teams and organizations requires us to evolve the plan as we learn and grow. Our ultimate intent is to help leaders reach their highest potential to lead. We are confident that ACHE's 2022–2024 Strategic Plan will help support your career and achieve your goals.

As we revisit the plan annually, we will look for your feedback to ensure the plan is an effective and relevant guide that will serve our profession well. We hope you are as excited as we are to set out on this path together. I invite you to learn more at ache.org/Strategy. ▲

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



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PAYERS AND PROVIDERS

Partnerships Lead to Success

By Maggie Van Dyke

Learn more about the Pennsylvania Rural Health Model. Go to [HealthcareExecutive.org/WebExtras](https://www.healthcareexecutive.org/webextras) to access a Q&A that provides more details on the collaborative process and results to date.

Anthem Blue Cross and Blue Shield had been trying to grow its Medicare Advantage plan in Maine for years. But its population remained flat at about 5,000 members.

Beginning in 2020, the health plan partnered with MaineHealth System to launch Anthem | MaineHealth Medicare Advantage Plans. Within two years, the co-branded plan had 14,000 members. It is now the fastest-growing plan in Maine.

“Pairing up our strong brand with the strong MaineHealth brand was ‘jet fuel’ for growth,” says Raul Smith, president of Anthem’s Medicare North/East region.

Partnerships like Anthem’s and MaineHealth’s run counter to historical insurer/provider

relationships, which typically revolve around negotiating payments and navigating denials and related revenue cycle challenges. “Historically, these relationships have been transactional and arm’s-length,” says John Poziemski, managing director, Kaufman Hall. “It’s been your quintessential zero-sum game, in which somebody wins and somebody loses.”

That dynamic is starting to change, as evidenced by an uptick in collaborative conversations, alliances and business arrangements between insurers and providers. “There are win-win

opportunities in the marketplace right now if payers and providers can better organize themselves accordingly,” Poziemski says.

The most effective partnership models vary, from collaborative contractual relationships intended to optimize value-based goals (i.e., improved quality, care access and cost management) to joint ventures and mergers aimed at launching enhanced health plan offerings and care delivery options (e.g., primary care access and digital health offerings). New payer-provider joint

ventures are launching with increased frequency.

“Irrespective of the market status or characteristics of these partnerships, health plans and providers are all seeking to drive and create value for the communities they are serving,” Poziemski says.

For instance, the overarching goal of the Anthem | MaineHealth brand is to “improve the lives of Maine’s Medicare community by becoming the leading Medicare Advantage plan,” Smith says. “How do we achieve that? We become the plan providing highly rated affordable coverage and the best access to care.”

In addition to driving increased value to patients/members and purchasers, these partnerships are helping both insurers and providers achieve strategic and business goals. For instance, providers benefit from access to covered member lives and beneficial payment arrangements. The volume fluctuations brought on by COVID-19 further revealed the limitations of the traditional fee-for-service payment model, explains Poziemski. “A lot of providers are rethinking their revenue and reimbursement models to ensure they can maintain resilience across their organizations.”

What does it take for insurer-provider partnerships to succeed, and how do

they drive value? The stories of two joint ventures provide a number of insights.

The Aetna-Inova Health Partnership

Aetna has formed several joint ventures with health systems over the past decade. One of these is Innovation Health, a 50-50 joint venture with Inova Health System that launched in 2013. An insurance company, Innovation Health offers commercial-based plans to employers in the Northern Virginia area. At the start of 2022, the company also launched a plan on the individual marketplace.

“Our ultimate goal is to grow membership by providing a differentiated clinical and member experience for people in this region,” says Sunil Budhrani, MD, CEO and CMO, Innovation Health. “We are working together to really improve the quality and delivery of patient care while reducing costs.”

The two organizations brought complementary assets to the table. Inova prides itself on services such as orthopedics, pediatrics and other specialties. In addition, the six-hospital system has the traditional care facilities needed to provide comprehensive inpatient and outpatient care. Aetna brought the necessary insurance capabilities, such as underwriting and broker sales, as well as intensive data analytics

“There are win-win opportunities in the marketplace right now if payers and providers can better organize themselves accordingly.”

—John Poziemski
Kaufman Hall

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PAYERS AND PROVIDERS

Partnerships Lead to Success

skills needed to glean insights from claims data and better manage patient populations.

The end product is more seamless, coordinated care. Health plan members often complain about getting lost in the care gaps that exist between enrolling in a health plan and obtaining care from network providers, according to Budhrani. “At Innovation Health, we hold patients’ hands throughout the experience,” he says. “We onboard them, then get them connected with a primary care doctor and

follow up to make sure they remain well and healthy.”

To ensure members have rapid access to care, Innovation Health also contracts with physician and provider groups that are not part of Inova. The company has also invested in telehealth capabilities, which have proved beneficial during the pandemic.

Network providers—inside and outside Inova—agree to share data with Innovation Health to improve and coordinate care. “These providers,

who are part of what we call our performance network, collaborate with us to provide proactive care that encourages people to stay well,” Budhrani says. “We meet regularly and share information that helps us close gaps in care, such as identifying members who would benefit from aggressive care management to prevent unnecessary hospitalizations.”

Network providers are financially incentivized to keep members as healthy as possible via value-based payment arrangements.

Rural Hospitals Partnering With Payers in Pennsylvania

More than 80% of U.S. rural hospitals are at risk of closing due to financial issues, according to 2020 data. Many of these hospitals have seen population declines in their service areas. In addition, they often rely on Medicare and Medicaid as their primary payers, which typically reimburse less than private insurers.

A unique demonstration project in Pennsylvania aims to address this issue by transitioning rural hospitals in the state to global budget payments, from both Medicare and private insurers.

The Centers for Medicare & Medicaid Services is providing funding to Pennsylvania to implement the five-year demonstration project, which began in 2019. Called the Pennsylvania Rural Health Model, the goal is that fixed global payments, determined in advance and paid consistently, will

give small rural hospitals financial footing. “We are looking to stabilize hospitals’ revenue, to give them time to assess their cost structures and reinvent themselves to, hopefully, provide a path to future sustainability,” says Janice Walters, COO at the Rural Health Redesign Center, which oversees the model for Pennsylvania.

Endless Mountains Health System, a 25-bed critical access hospital in the northeastern Pennsylvania town of Montrose, some 40 miles north of Scranton, has been participating in the model since it launched in 2019. “The biweekly payments from Medicare, which is our biggest payer, have significantly stabilized our cash flow,” says CEO Loren Stone, FACHE. “Under fee-for-service, it was ‘feast or famine.’ We had busy months where we’d be generating a lot of cash and then slow times that were very difficult.”

Total costs of care for Innovation Health small business members who choose performance network providers have decreased by 36% year over year. These members have a 24% lower rate of avoidable hospital admissions and a 27% lower rate of avoidable emergency room visits.

Growth-wise, the plan is also faring well. The commercial health plan is one of the fastest-growing in Northern Virginia with more than 125,000 members.

The Anthem-MaineHealth Partnership

Formed nine years ago, Innovation Health is one of the longest established

payer-provider joint ventures in the United States. In comparison, Anthem | MaineHealth is one of the newest, founded two years ago.

A Medicare Advantage plan, Anthem | MaineHealth offers HMOs and PPOs as well as dual-eligible special needs plans. While MaineHealth is the anchor provider in the network, the plan also contracts with providers outside of MaineHealth to ensure adequate access to members in all the communities it serves.

Since launching, Anthem and MaineHealth have been focused on aligning various processes to achieve

the goal of improving lives in Maine's Medicare community. Work groups made up of leaders from the two organizations meet regularly to discuss topics such as product design, care management, utilization management and Medicare star ratings.

"We have a lot of data at Anthem, and we provide work groups with that data to help optimize opportunities to meet our members' needs," Anthem's Smith says.

For example, after the COVID-19 pandemic began, claims data revealed that many Anthem | MaineHealth members had missed their annual

The global payments have proved particularly beneficial during the pandemic. EMHS saw 30% to 40% declines in volumes in 2020.

Participants in the model must develop transformation plans geared toward lowering avoidable utilization and costs. EMHS is currently focused on reducing utilization related to respiratory-related conditions, such as chronic obstructive pulmonary disease. A data analysis, paid for by the demonstration project, identified that 28% of EMHS admissions were related to pulmonary illnesses. To lower unnecessary admissions, the hospital is working on putting wraparound services in place for COPD patients, such as medication consults with pharmacists and a pulmonary rehabilitation program.

EMHS' two largest private payers are also participating in the model. Private payers are not yet

paying regular global payments. Instead, they pay claims as submitted up to an annual budget cap, which was determined based on historical claims from 2015 to 2017.

For Stone, one of the most beneficial aspects of the demonstration project has been the high level of collaboration. "It's been one of the best partnerships with a state organization that we've ever been involved in," he says. "They [Pennsylvania's Department of Health and the Rural Health Redesign Center] worked with us providers as well as the private insurers to come up with the playbook and the rules. They didn't just say, 'Here's a program that we've created, and here's how we're going to run it.' They sought input from both sides, were transparent throughout the entire process and really stewarded the partnership."

wellness visits. Anthem shared specific names of members who were due for an exam, which enabled MaineHealth to engage directly with members in need of a checkup.

Innovation is another goal of the joint venture. “MaineHealth providers have their ear to the member more than we do at times,” Smith says. “Having MaineHealth involved in product design and walking us through what is needed in the market is invaluable.”

As an example, Anthem | MaineHealth members can take advantage of its

“Essential Extras” package, which allows them to choose, at no extra cost, one extra benefit from a list of nontraditional benefits, most of which address social determinants of health such as lack of transportation. “We’re taking a proactive approach to address the whole health of members,” Smith says.

With input from stakeholders such as MaineHealth, the health plan expanded this program in 2022 to include three new benefit choices:

- A flex card to purchase up to \$500 of dental, vision and hearing services/items a year.
- A healthy groceries card, which provides up to \$50 a month to purchase healthy food at participating stores.
- In-home support, which pays for up to 60 hours of assistance per year to help with house-keeping chores, running errands and providing companionship.

In 2021, Anthem | MaineHealth achieved a four-star Medicare rating for its first year as a joint venture health plan. Less than one-fourth of initial plans attain a four-star rating one year after launch, according to Smith. “The Medicare Star program is becoming more and more geared to the consumer’s healthcare experience, which is driven by the provider. So, working with MaineHealth is key to improving our rating.”

Keys to Success Now and Tomorrow

One of the biggest challenges for payer-provider partnerships is transcending the friction that once existed between the two entities, according to Poziemski. “A lot of the people working at these organizations have long institutional knowledge of how they’ve worked together in the past,” he says. “It’s been acrimonious at times and not collaborative.”

One key to success, Smith advises, is focusing on the partnership’s common goals, such as improving outcomes for members. “Certainly, whenever there’s a point of contention, you need to step back and remind yourselves of the goals of the partnership.”

As the Anthem | MaineHealth relationship has progressed, Smith has seen increased collaboration among staff from the two organizations when such topics as care coordination and claims management arise. “There’s more feedback and better responses on both sides,” he says. “There’s a credibility that has built up, which allows us to say, ‘Here’s why we’re doing that. It’s about, for example, managing costs so we can reinvest in member benefits and provide a better offering.’”

Other keys to success involved in payer-provider relationships include the following:

Using a centralized infrastructure, which supports population health management. Many payer-provider

“Pairing up our strong brand with the strong MaineHealth brand was ‘jet fuel’ for growth.”

—Raul Smith
Anthem

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partners are discussing how to best create a consolidated infrastructure for population health efforts, according to Poziemski. “They’re looking at how to combine collective resources to reduce some of the redundancies that exist when each partner is independently providing these capabilities.”

Innovation Health made major investments in centralized care management programs for health plan members. One such program is the Innovation Health Nurse Concierge Team. Nurse navigators help members coordinate their care,

including hospital discharges and follow-up care.

Another centralized program, the Multidisciplinary Care Team, provides intensive care management to the 5% of members most in need of care. Led by a medical director, the team includes pharmacists, social workers, behavioral health specialists and dietitians. After evaluating high-risk members, the team actively addresses social determinants of health or other issues that are exacerbating medical problems.

A 2019 study found that the team’s work has significantly reduced per-member-per-month costs. Inpatient PMPM costs were \$101 lower for high-risk members followed by the team, compared with controls. Outpatient PMPM costs were \$92 lower, and medical prescription PMPM costs were \$33 lower.

To ensure the success of these care management programs, Aetna and Inova integrated certain key information systems, enabling teams to exchange data to do their best work.

Building trust leads to more patient engagement. Member engagement has proven to be a key value-driver of payer/provider partnerships—and it’s helping members stay well. “Patients and members have a significant amount of trust in their doctors, nurses and providers,” Budhrani says. “Our survey data clearly show that one of the powers of our

joint venture is that members will engage with us because we have the providers as part of our makeup.

Listening to the market presents added opportunities. “Every market is telling health plans and providers something, if they’re listening hard enough,” Poziemski says. “I think it’s key to really understand what different market segments and purchasers are looking for.”

For example, by listening to the Maine market, Anthem | MaineHealth included more flexibility in its Medicare Advantage provider networks. “We didn’t have a huge presence in the PPO market, but now after listening to purchasers, we’ve invested in the PPO and hope to see growth there this year,” Smith says.

Understanding readiness.

Poziemski stresses the need to be transparent about readiness—both market readiness and organizational readiness to pursue payer-provider partnerships and value-based payment arrangements.

“There’s no organization that’s 100% ready to take on value-based care in every way at every dimension but, when payers and providers partner, there has to be a willingness to work together to improve the readiness of the collective parties.”

Maggie Van Dyke is a freelance writer and editor based in the Chicago area.

“Our ultimate goal is to grow membership by providing a differentiated clinical and member experience for people in this region.”

—Sunil Budhrani, MD
Innovation Health

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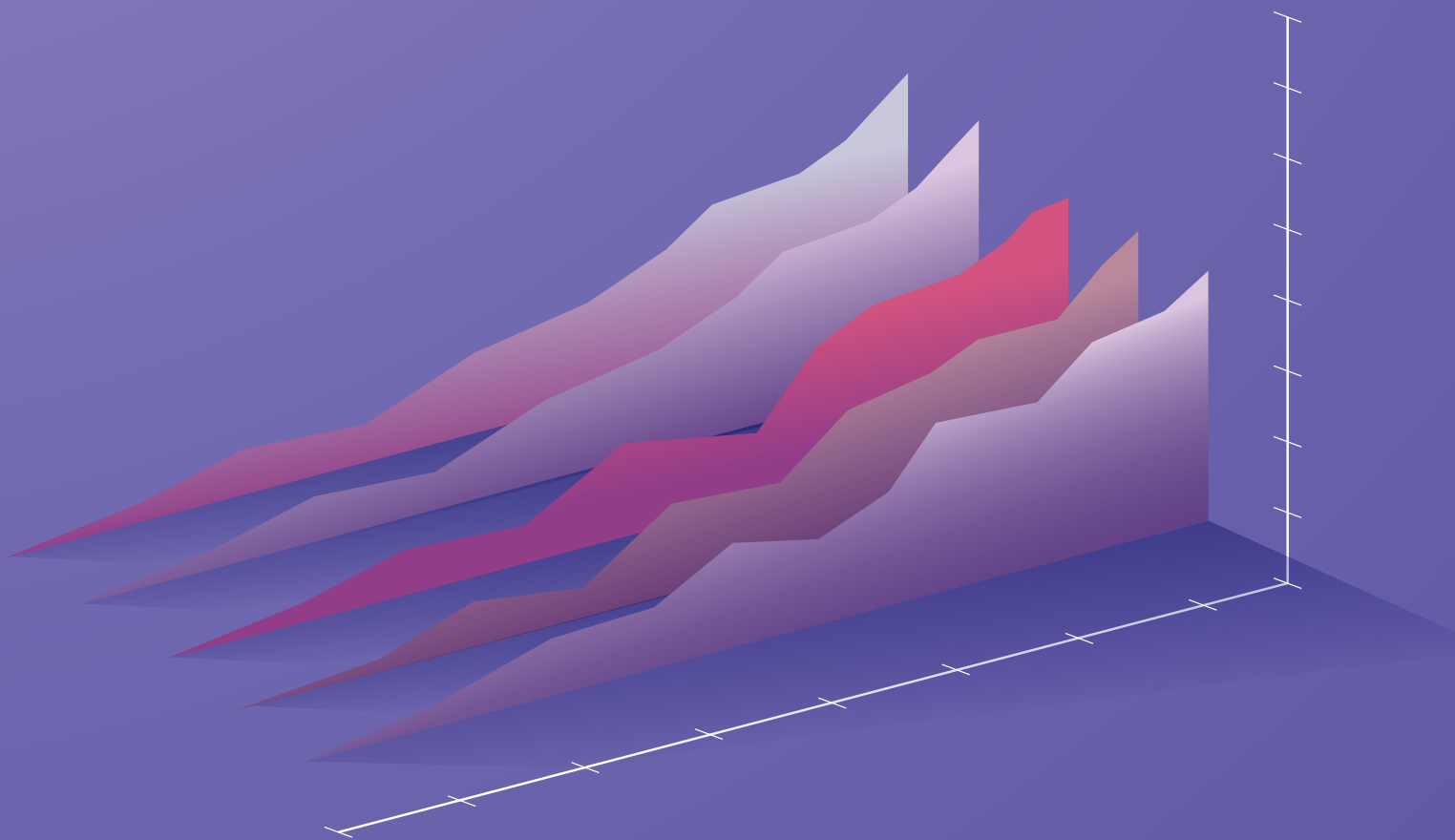
Phone Charger/Sanitizer



Polo Shirt Men's/Women's Sizes



Have You
Future-Proofed
Your Organization?



Planning for success—and stability—now and down the road.

By Jessica D. Squazzo

Though underlying issues stemming from the pandemic will not soon be forgotten, forward-thinking leaders are already exploring financial opportunities to mitigate future scenarios that were once unanticipated, if not downright unimaginable.

As organizations prepare to address future uncertainties, what are some best practices? How can the healthcare field at large most effectively adapt to meet the needs of patients and communities in the months and years ahead?

The *2021 Impact of Change Forecast*, produced by Sg2, an analytics-based healthcare intelligence firm that is part of the Vizient family of companies, provides valuable insights into what most likely lies ahead in the coming year. Topping its list are dynamic shifts in how and where care will be delivered going forward. A principal of the firm, who serves as its medical director of quality and strategy, Madeleine McDowell, MD, FAAP, foresees procedures such as knee or hip replacements potentially moving from the hospital setting to ambulatory centers, while low-acuity ED volumes are likely to shift to physician offices or telemedicine platforms.

Patient acuity is also expected to rise, caused by an increase in chronic disease among patients and COVID-19 related factors such as patients delaying care during the pandemic and effects of the long COVID-19 condition.

“Many of these shifts were occurring prior to the pandemic, but it has certainly accelerated them,” McDowell says. “They’re going to be challenging to navigate because they are changing month to month. It all impacts your resource needs, staffing and facility designs. For example, do you need more ambulatory surgery centers, and how do these centers need to be designed to optimally care for this new set of patients? Do you need to consolidate your physician offices into a center that can handle multidisciplinary team-based care, ancillary diagnostics or telehealth services?”

While each organization faces unique circumstances in this ever-evolving environment, *Healthcare Executive* identified several that are employing innovative solutions to help ensure their fiscal and operational success, while maintaining patient satisfaction amid an uncertain future.

Hospitals will continue to experience rapid patient growth by 2029

AMBULATORY SURGERY CENTERS

25%

OUTPATIENT DEPARTMENTS

19%

Source: Sg2's 2021 *Impact of Change Forecast*.

Have You Future-Proofed Your Organization?

FirstHealth of the Carolinas: Maintaining Financial Stability

FirstHealth of the Carolinas, a private, not-for-profit healthcare network headquartered in Pinehurst, N.C., maintained a “stable outlook” with Fitch Ratings in 2021 and an “AA” rating with the ratings agency for its strong financial profile assessment and stable operating performance. The four-hospital, 610-bed health system credits its financial stability, in part, to well-coordinated efforts across its hospitals and clinics to manage the influx of COVID-19 patients and its expansion of telehealth services.

Looking ahead, FirstHealth has numerous plans in the works to maintain that stability. At the top of the list is continuing to expand its services into the health system’s secondary market. The goal, according to Jeffrey A. Casey, CFO, is to offer increased access to specialty care, including orthopedics, urology, obstetrics and gynecology, vascular services and ear, nose and throat services in the rural areas it serves.

“Offering these services in outlying areas allows FirstHealth to expand its geographic footprint and brand to ensure it provides patients with the best options for specialty services,” Casey says.

Other plans to continue the organization’s momentum include increasing capacity in its EDs through expansion of its urgent care footprint. Currently, the 10 walk-in locations in the health system’s primary care and secondary services areas cover more than six counties in the mid-Carolinas. A new location is slated to open in early 2022, adding an additional county.

FirstHealth is also prioritizing recruitment and retention, finding creative ways to overcome staffing shortages while attracting and retaining nurses. The health system is offering generous recruitment and retention bonuses for staff members. To help support resilience and work-life balance,

FirstHealth has also implemented flexible scheduling options for professional registered nurses, including a weekends-only option, and a systemwide float pool. Looking to address future staffing needs, the system has implemented a nurse extern program, offering nursing students the opportunity to gain hands-on experience working alongside experienced registered nurses.

Having a strong balance sheet in place before the pandemic helped FirstHealth make quick moves and prioritize its market deci-

sions, according to Casey. “We have done an outstanding job of controlling expenses coupled with smart growth in our key markets and service lines,” he says.

Another key to future success will be a continued commitment to clear communication across its system and with patients. “We will continue to work as a system and be transparent with staff and the community on our goals and objectives,” Casey says.

Geisinger Health: Defining Its Path Forward

From the outset of the pandemic, Geisinger Health, Danville, Pa., vowed to do more than just help its staff and the more than 1 million people it serves throughout central Pennsylvania navigate the pandemic in crisis mode. Writing in a June 11, 2020, *Harvard Business Review* article, President and CEO Jaewon Ryu, MD, and colleagues described the health system’s efforts as an “innovation initiative” rather than a “damage-mitigation exercise.”

“Many of these shifts were occurring prior to the pandemic, but it has certainly accelerated them. They’re going to be challenging to navigate because they are changing month to month.”

—Madeleine McDowell, MD, FAAP, Sg2

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Industry Perspectives: The Current and Future State of the Healthcare Landscape

Join leaders Richard J. Pollack, president/CEO, American Hospital Association; Matthew D. Eyles, president/CEO, America's Health Insurance Plans; and Ernest J. Grant, PhD, RN, FAAN, president, American Nurses Association, for this fireside chat to address critical issues facing U.S. healthcare providers today.

Leadership Insights Sessions Advance healthcare with forward-thinking healthcare leaders. Here are just some of the sessions planned:

- Transformative Leadership: Building Trust and Equity During Unprecedented Times
- The Healthcare System of the Future
- Shaping the Future Workforce
- Innovations in Supply Chain Infrastructure

Solutions Center The reimagined Solutions Center is the place to be for education, networking and relaxation at Congress. Don't miss the new Ignite Stage, where industry leaders will make short presentations on cutting-edge topics. Also be sure to visit the Health Administration Press bookstore to purchase books at a 50% discount, as well as the ACHE Member Services booth, the ACHE Safety booth and the Learning Concierge booth.

Have You Future-Proofed Your Organization?

When asked why the organization adopted this mindset, Geisinger Executive Vice President and COO Matthew M. Walsh notes that at Geisinger, necessity isn't just the mother of invention, "it's really what drives all our innovations," he says. "We innovate to solve problems, whether it's a fresh-food pharmacy to address food deserts or our Proven Recovery program to manage outcomes after surgery. We're constantly looking for ways to solve problems we see in our communities."

Despite challenges brought about by the pandemic, Geisinger saw an opportunity to accelerate innovation even more to meet the community's needs going forward. For instance, the organization increased its use of telemedicine, improved communication with patients and employees, and shortened the time frame from idea

to delivery with new initiatives, all strategies it plans to carry forward. And although the pandemic is still straining resources and capacity (at press time, Geisinger had about 200 inpatients with the virus across its facilities), the nine-hospital health system never stopped executing toward its strategic plan, according to Walsh. In fact, it has launched 10 capital projects since the pandemic began.

These projects include the opening of the health system's first microhospital, Geisinger Medical Healthplex in Muncy, Pa., which was expected at press time to open in January 2022. The facility will include a full-service ED, imaging and lab services, oncology services and general surgery, an operating suite, 20 inpatient beds, and a multispecialty clinic providing adult and pediatric primary care, among other services.

What Leaders Can Plan On

What are some industry changes leaders should be aware of as they make plans for their organizations? Following are some key areas of focus, according to Madeleine McDowell, MD, FAAP, principal and medical director of quality and strategy, Sg2.

Revenue will not keep pace with rising costs, even though volumes should recover in 2022 and return to pre-pandemic levels. Rising costs will be due to increased patient acuity and shifts to lower-cost care settings (for example, higher-cost, more complex patients moving from inpatient operating rooms to ambulatory surgery centers).

Care redesign will be essential to meet the needs of changing patient acuity and increased use of nonhospital/non-ED settings. The goal is to have care team members practicing at their highest level of licensure, enabling clinicians, staff and customer-service representatives to deliver care more efficiently and effectively. Clinical leaders will need to get ahead of these changes by redesigning care around patients' needs, supported by emerging artificial intelligence technologies. In addition to considering expansion of virtual services, healthcare organizations will need to consider digital support services they can provide to care for patients at home and across care settings.

Ambulatory footprint and facility design investments might be necessary. For example, organizations might consider designing a separate part of their ED to care for an influx of behavioral health patients.

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Hope Through History

As difficult as the present is, the American past is the story of challenges overcome, crises resolved and progress made. In this nonpartisan speech, Jon Meacham walks audiences through moments that have seemed intractable—the 1918 influenza pandemic, the battle against polio, Franklin Delano Roosevelt’s response to the first days of the Great Depression, Winston Churchill’s decision to fight on against Adolph Hitler, and the Cuban missile crisis—to offer lessons for leaders in how to endure and prevail when everything appears hopeless.



Jon Meacham
Historian/Author

Arthur C. Bachmeyer Memorial Address

The Future of the U.S. Healthcare System

How has the U.S. healthcare system been reshaped in the wake of recent events? Who have been the big winners and losers? What are the likely changes on the horizon? Beyond telemedicine, how will payment models and workforce issues change? Join physician, health policy researcher and public health expert Ashish K. Jha, MD, as he shares his insights into these key questions and more.



Ashish K. Jha, MD
Dean
Brown University School of
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Many of the new programs, such as Geisinger 65 Forward, a health and wellness primary care model designed exclusively for those aged 65 and over, are designed to deliver care more efficiently and to keep patients healthier and out of the hospital. These goals align with the health system's overall commitment to value-based care, according to Walsh.

As Geisinger continues moving forward with executing its strategic plan, it will take successful short-term solutions and innovations it created during the pandemic and turn them into effective long-term processes and policies.

"We've solved some significant problems and delivered high-quality care faster and more effectively than ever before,"

Walsh says. "We've developed those muscles; now we have to continue to work them in a way that allows us to define our path forward."

St. Vincent Health: Growth After a Comeback

Witnessing the successful opening of the new, eight-bed St. Vincent Health Hospital in Leadville, Colo., in September 2021, one might not realize that it was built largely during an historic pandemic, or that the organization was on the brink of financial peril less than a decade ago. While many rural hospitals are experiencing financial struggles exacerbated by the pandemic, St. Vincent has fared significantly better. Describing its own "phoenix rising from the ashes" scenario, CEO Brett Antczak, CMPE, and an ACHE Member, notes that these challenges have, in fact, given St. Vincent a strategic advantage. In part a result of its prior financial struggles, the organization had already experienced the suspension of some services, or the need to place certain surgeries on hold—difficult decisions that hospitals have had to make due to COVID-19. "We were used to living in what the other rural hospitals

came to view as their 'new world' with the pandemic," Antczak says. "As they have been adapting to that new world, we've been readapting and planning to jump into the world that they had all been living in prior to the pandemic."

"We have done an outstanding job of controlling expenses coupled with smart growth in our key markets and service lines."

—Jeffrey A. Casey, FirstHealth of the Carolinas

Part of the success of being able to rebuild its financial stability—and literally build the new facility—has been due to a community that has "rallied together," per Antczak, providing financial support, including grants.

Not uniquely, giving the lingering global supply-chain crisis, St. Vincent experienced its own challenges in a minor but essential aspect of opening its new facility. When a contractor faced a shortage of the hospital-grade

epoxy grout needed to meet the organization's standards, he combined excess materials from other parts of the hospital to complete the job on time and on budget.

Problem solved: "True to the ingenuity of folks in this community," Antczak notes.

Banner Health: Strategic Investments

Throughout 2020, Banner Health, Phoenix, has made growth an imperative. In fact, it is doubling down on it, according to the organization's Chief Strategy and Growth Officer Scott Nordlund.

"From my perspective, no matter what is going on in the environment, growth is an imperative," he says. "You cannot shrink your way to success. There are really no examples out there that I can think of in any industry where an organization is not growing and yet it's considered successful."

Though the organization has had to tighten its expenses and shift resources in response to the

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Malcolm T. MacEachern Memorial Address

Workforce Solutions for the Modern World of Healthcare

To say that the healthcare workforce will be transformed by recent disruption would be an understatement. From pivots to virtual work and medicine to increases in home-based and digital healthcare, the healthcare workforce and the organizations that employ them will be stretched significantly in the years to come. In this talk, Nancy Snyderman, MD, will explore a variety of workforce solutions worth contemplating, and in some cases implementing, in this new, complex world.



Nancy Snyderman, MD
Former Chief Medical Editor
NBC News

Leon I. Gintzig Commemorative Address

A Quantum Life: My Unlikely Journey From the Street to the Stars

Hakeem M. Oluseyi, PhD, while growing up in some of the roughest neighborhoods in the country, discovered a love of science and space. Throughout his early life, he was repeatedly faced with circumstances that would make most people give up, but he never did. Today, as a world-renowned astrophysicist and the former Space Science Education Lead at NASA, Oluseyi inspires audiences around the world. He will wow this session's audience with a look at his mind-bending scientific research while motivating them with his personal life story.



Hakeem M. Oluseyi, PhD
Astrophysicist

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pandemic, it continues to build its asset and service portfolio. Among its successes in 2020 was the acquisition in October of Wyoming Medical Center, which expanded the health system's existing footprint in that state (Banner expects to fully integrate the medical center by Jan. 1, 2022). In November 2020, it opened the 124-bed Banner Ocotillo Medical Center in Chandler, Ariz., the health system's first new hospital built in Arizona since 2010.

"We have a really disciplined approach to where we want to grow and over what period of time—a five-year playbook that is always running," Nordlund says.

Technology is another area of growth that is a top priority. "We are still committing first call capital allocation to technology—that is a board mandate for Banner Health," says CFO Dennis Laraway. Digitization is a particular focus area.

"The digitization of our system is something our board actually has turned into a long-term initiative," Nordlund adds. "For the next three years, we have a fairly substantial tranche of investment going into that."

The digital investments will include assets such as hospital-at-home services, remote monitoring, prescribing of digital therapies and personalized digital engagement tools, as well as a commitment to making sure patients have a similar registration and billing experience across the entire care ecosystem. These investments are aimed at helping patients access care more easily and have a more integrated experience—something that is especially important to Banner Health, which is both provider and payer.

"Digitization is integral to solving navigational tools, referral management and scheduling—just the ability to be able to move through the system seamlessly," Laraway says.

The health system also is committed to developing and investing in strategic vendor partnerships to help advance its goals. "The right partners can help us move faster and can allow us to leverage, influence and even co-develop solutions that can help us tap into larger R&D resources," Nordlund says. Strategic vendor partnerships will continue to help Banner Health manage supply chain disruptions, develop solutions for managing population health, solve logistics and payment challenges, and uncover operations efficiencies, as some examples.

"As they have been adapting to that new world, we've been readapting and planning to jump into the world that they had all been living in prior to the pandemic."

—Brett Antczak, CMPE, St. Vincent Health

Banner reinforces its commitment to forging valuable partnerships with its Innovation Partnership Alliance, a group developed to mine for new strategic partners or expand relationships with existing ones. "Through the alliance, we've been able to go deeper than just a vendor-purchaser relationship into some more strategic offerings and partnerships," Nordlund says.

Staying Nimble for What Lies Ahead

The challenges of the past two years have highlighted the industry's ever-dynamic nature; adapting to changes will continue to be an important strategy for organizations of all sizes and in all places. As healthcare organizations and the executives who lead them continue forging a path forward, they might not always know exactly what new challenges and opportunities to expect, but one thing is certain—they will need to be nimble enough to ride the continued waves of change.

Jessica D. Squazzo is a Chicago-area-based writer and editor.

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The New Normal: Fostering Resilience and Teamwork in the World of Healthcare

As someone with a unique macro and micro view of modern healthcare, Jennifer Ashton, MD, will provide thought-provoking insights into the problems facing the healthcare field. In addition, she will offer motivational guidance on working outside of one's comfort zone, being a team player and taking advantage of both professional and personal obstacles.



Jennifer Ashton, MD
Chief Health and Medical
Correspondent
ABC News

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Paul B. Hofmann, DrPH,
LFACHE

Implementing Crisis Standards of Care

Executives should promote their ethical application.

More than 10 years ago, the National Academies Press published the results of the Institute of Medicine's forum on medical and public health preparedness for catastrophic events (*Crisis Standards of Care: Summary of a Workshop Series*, 2010). Given the inability to predict the timing and severity of a future calamity, the forum's participants recognized that waiting for disasters to strike would be too late to create comprehensive and rational crisis standards of care.

It is difficult to imagine a more urgent challenge testing the capacity of healthcare leaders to demonstrate our competence, mettle and resiliency.

As many executives now know, crisis standards of care are implemented when resources are insufficient to meet the needs of all critically ill patients, and they cannot be transferred to other hospitals. It is a triage process to focus on patients with the greatest likelihood of survival. Historically, this type of triage process routinely took place in a mobile army surgical hospital unit with

clinicians providing care for the wounded near the front lines of combat. Because of COVID-19, however, numerous hospitals have been compelled to adopt a highly refined method for determining which patients will be the beneficiaries of intensive treatment and which ones should only receive pain and symptom management, frequently designated as comfort measures.

Ethical Issues Requiring Attention

Identifying ethical issues directly affecting patients should have priority; however, the significant impact of crises on family members, clinicians, the rest of the staff, the institution, its governing body, the community and other constituencies must also be considered.

Developing a meaningful ethical checklist with broad support requires extensive consultation with individuals, committees and external organizations. For example, ethicists, medical and surgical chiefs of service, clergy, ethics committees, attorneys, trustees, other hospitals, state medical societies, as well as local, regional and state hospital associations should be engaged in the deliberative process.

Fortunately, plenty of informative resources are available. At least 10

states, including Alaska, Arizona, Arkansas, California, Hawaii, Idaho, Massachusetts, Minnesota, Montana and New Mexico, have adopted crisis standards of care. Some states, like California, mandated that all hospitals post their crisis standards of care on their websites.

In addition, on April 5, 2020, the American Medical Association issued guidance from its *Code of Medical Ethics* ("Crisis Standards of Care: Guidance From the AMA Code of Medical Ethics"), noting the code is "grounded in core values of respect, compassion, objectivity, transparency and fairness that underly the difficult decisions about allocating scarce resources that arise in a pandemic." The AMA offered specific advice for healthcare providers when making initial triage decisions about limited critical care resources for individual patients and for periodically reassessing those decisions:

- Triage decisions must be based on criteria related to medical need, *not* on nonmedical criteria such as patients' social worth.
- When criteria of medical need distinguish among patients, allocate limited resources first based on likelihood of benefit or to avoid premature death and then to promote the greatest duration of benefit after recovery.
- When criteria of medical need do not substantially distinguish among patients, allocate limited resources by an objective and transparent mechanism, such as random choice or lottery to

minimize potential bias, as opposed to “first come, first served,” which may unfairly privilege patients who have the means to seek care promptly.

- Periodically reassess ongoing life-sustaining treatments for all patients. When continued treatment is substantially unlikely to achieve the intended goal of care, it may be withdrawn.
- Explain the policies and procedures by which triage decisions that allocate life-sustaining treatments are made and provide a process for appealing decisions when such treatments will be withheld or withdrawn.
- Palliative care must be provided when life-sustaining treatments are withheld or withdrawn.

A Representative Ethical Checklist

Many states provide helpful guidelines, and those produced by the Minnesota Department of Health are particularly substantive. The MDH commissioner established a scientific advisory team composed of critical care physicians, primary care physicians, psychiatrists, pharmacists, ethicists, hospital administration, legal and other disciplines. The team developed guidance for hospitals, health systems and healthcare coalitions on strategies to provide optimal allocation of scarce resources during crisis standards of care situations.

The MDH ethical checklist (“Crisis Standards of Care Ethical Checklist”) contains specific items in four categories:

- 1. Duty to care strategies**, including subsections pertaining to obligations to patients and support for healthcare workers.
- 2. Proportionality and equity in freedom-limiting intervention strategies** with subsections referencing social distancing and proportionality.
- 3. Fair and consistent stewarding resource strategies** concerning coordination, key workers, and triage, rationing and allocation of resources.
- 4. Duty to plan information**, with a focus on accountability and transparency.

It is evident that Children’s Mercy Kansas City (Mo.) had these concepts and others in mind when the institution responded to the pandemic. “The Culture Imperative: Preserving Your Organization’s Soul” is a superb article authored by Paul D. Kempinski, FACHE, Children’s Mercy Kansas City president/CEO, and Alice Berry, DDS, and Katharine Berry, MD, Endowed Chair in Executive Leadership. In the article, published in the September/October 2021 issue of the *Journal of Healthcare Management*, Kempinski explains the philosophy that guided the organization’s approach, stating, “It has been said that adversity does not build character in an individual; it reveals it. The same is true for organizations. Any organization that is preparing to confront a crisis but leaves its vision, values or mission behind is entering the battlefield unarmed. Values are not weights

that hold organizations back during a crisis: they are the compass that clearly points the way forward.”

Concluding Observations

Although the admonition “nothing about us without us” is most often associated with the disability empowerment movement, its relevance for the development and application of crisis standards of care cannot be overemphasized. Input from the hospital’s patient/family advisory council will increase the likelihood that the patient’s voice will be heard. Similarly, given the disparities in accessing healthcare services affecting people of color and LGBTQ communities, crisis standards of care should signal every effort has been made to eliminate any potential biases. Furthermore, a hospital ethics committees should periodically revisit its crisis standards of care document to evaluate whether other factors may be relevant, such as pregnancy, age, comorbidities and vaccination status.

Future pandemics and casualties associated with major disasters like earthquakes and hurricanes are inevitable. It is difficult to imagine a more urgent challenge testing the capacity of healthcare leaders to demonstrate our competence, mettle and resiliency. ▲

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



Robin S. Damschroder, FACHE

Uniting Stakeholders for a Positive Outcome

There are four key elements leaders can deploy to create engagement and unity.

Health systems are complex operations that need significant capital and operating investments to fund critical infrastructure to support patients, communities and members. These investments are funded primarily by single-digit operating margins. These operating margins can easily be stressed by external and/or internal factors that can quickly turn financial performance negative and render any long-term strategic planning inoperable. There is, however, a solution.

Long-term strategic and operational financial sustainability is gained through disciplined investing and management of daily operational metrics (quality, safety, experience and finance). Two fundamental philosophies hold true whether discussing capital investing or daily

operating performance management: Do the right thing for the patient or the health plan member, and sound financial performance is not mutually exclusive from top-quartile performance in quality, safety and experience. It seems simple, but the complexity lies in supporting people to work together and unite for a purpose that allows resources—both human and otherwise—to be focused to maximize the return for both external and internal stakeholders.

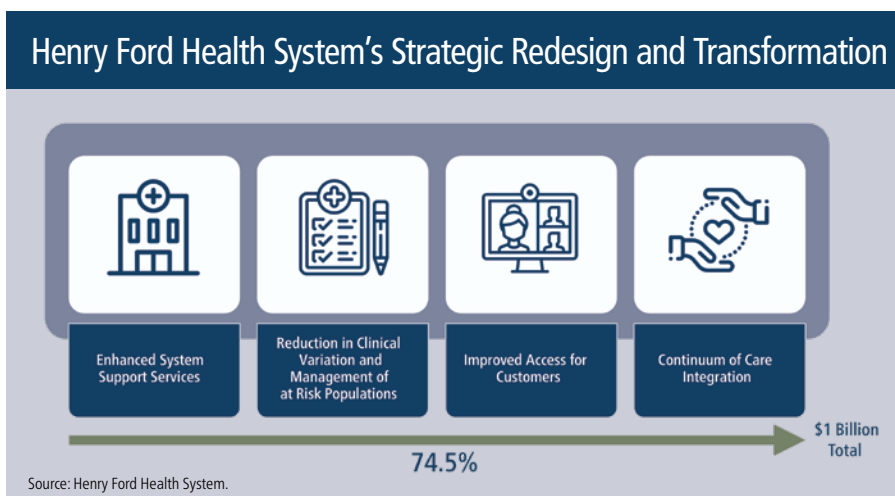
To drive clarity and agility in decision-making—financial or otherwise—leaders at all levels must unite stakeholders to promote executive performance improvement or transformational change to deliver desired outcomes. Many times, leaders forego performance improvement and change

management fundamentals and just rely on traditional techniques and tools alone to design solutions, particularly financial ones. To be honest, it can work in the simplest of cases but results in many false starts. Much of the complex, large-scale performance improvement or transformational change to drive the long-term sustainable operational and financial outcomes facing most health systems today requires the need to rely on sound performance or transformation frameworks to start slow and finish fast.

There are many frameworks, so choose one that aligns with the culture and language of your organization to avoid confusion. Many times, stakeholders enter at different points in the process with multiple perspectives. In the pursuit of quick solutions, and without a full understanding of the ramifications, clarity of the problem to be solved is often overlooked.

Performance-improvement frameworks offer a pause and an opportunity to bring stakeholders quickly to the same level of understanding. Stakeholder solutions can be generated to solve problems. But without shared understanding and agreement on the problem, the solution-seeking process leads to multiple solutions or over-weighted solutions trying to satisfy multiple stakeholder interests. The solutions lose focus, and the

This column is made possible in part by BRG.



investment requirement begins to outweigh intended results, which leads to inaction, gridlock, and negative or unintended operational and financial outcomes. Clarifying the problem to be solved and working it is worth the extra effort to speed the solution.

Teams can also identify several problems to be solved with individual or bundled solutions to address complex systems or processes. Often, the result is the formation of a playbook that requires a multiyear approach to complete a full redesign/modernization effort to achieve full value.

What drives stakeholders to unite behind a problem and solution? How can leaders engender others to unite? Key elements leaders can deploy to create engagement and unity among stakeholders and teams include the following:

Lead With the Customer

The patient's voice can never be shared enough. Many organizations open their meetings with a patient story, but a story that also ties directly to problem(s) being evaluated is a powerful addition. There are many interests in any room of stakeholders, but the customer's interest needs to be first.

Value and Promote Transparency

Sharing the same facts, data, analyses and qualitative information promotes transparency that allows a team to build trust and reduce fear. Allowing team members to challenge and question the data and facts while acknowledging any limitations will drive a better understanding by all. Team members who have been heard feel valued and develop an ownership in the decision-making process, even if their solution is not moved forward.

Ultimately, teams that have the same information and a similar understanding of the data and facts can unite more quickly around problems and solutions.

Empower the Team

Identify the most knowledgeable, passionate stakeholders, which includes those closest to the work. Value the diverse perspectives and backgrounds required to evaluate complex decisions when selecting the team. Clearly identify the level of authority they have been given. Are they informing, deciding or recommending the solution?

Embrace the Data

Data in all forms can diffuse emotion and anecdotes. The use of historical trends, benchmarks, comparative analyses, research results and best practices can drive deeper understanding of the opportunities. This data can also move teams beyond cultural boundaries or barriers that exist organizationally or within departments. Powerful data analyses can generate the possibilities that are often missed or overlooked. Teams can paralyze themselves if they have too much data, so tailoring data analyses to focus on the vital and critical data for decisions to be made is necessary.

Henry Ford Health System

Henry Ford Health System's performance improvement program, Strategic Redesign and Transformation (see chart on Page 30), is expected to result in \$1 billion in either cost savings or growth that will accelerate margin improvement from 1% to 3.0%-3.5% over five years (pre-COVID-19).

It has had historical success in advancing playbooks in earlier financial

stewardship and sustainability programs. But, the difference with the current SRT programs is the deep focus on customer access, clinical variation and population health to drive long-term quality, safety and experience to attain the financial result. Earlier programs highlighted the short-term and unintended impacts of focusing only on the financial outcomes. Much of financial waste is often derived from workarounds that team members may need to do to ensure quality and safety or improve patients' experience, which can lead to poor financial outcomes.

Prior to March 2020, Henry Ford Health system had designed 75% of the initiatives and was realizing gains that had its operating margins steadily improving to 2.2% in two short years. Its COVID-19 learnings only strengthened its commitment to the performance improvement and change management framework that were in place for SRT teams. This allowed the organization to pivot quickly to areas that needed critical redesign during the first surge and through the waves that followed, as well as the current labor shortage the industry is experiencing nationally.

Henry Ford Health System has had the opportunity to learn from initiatives that failed or faltered. We strive to have a learning culture that allows us to rapidly learn from our mistakes and build trust among HFHS stakeholders to take the risks required for performance improvement and transformational change. ▲

Robin S. Damschroder, FACHE, is executive vice president/CFO, Henry Ford Health System, Detroit (rdamsch1@hfhs.org).



Neil J. Moore, FACHE

Tailored Technology

Sophisticated use of TVs improves patient experience.

When I arrived at NYC Health + Hospitals/Queens nearly one year ago to assume the position of CEO, the smart TVs available to all patients were one of the first things that caught my attention. A sophisticated system like this, I thought, tells people who come here for their healthcare that we are a hospital of choice, with top technology for improving patient experience. The fact that we can customize this equipment to communicate the exact information we want is nothing short of remarkable. I soon learned that what started as an upgrade of our hospital's TV service evolved into something much more comprehensive.

HCAHPS satisfaction scores have already begun to advance since the smart TVs were implemented in fall 2020.

An Individualized Approach

The advent of these smart TVs in patient rooms ushered in the dawn of telehealth at NYC Health + Hospitals/Queens, allowing the hospital to expand its educational abilities and tailor them to each patient according to their individual needs. This interactive healthcare system

now exists in the Queens Cancer Center and in several departments throughout the hospital, including perioperative, labor and delivery, mother and baby, the regular medical-surgical unit, and the extended observation unit.

When NYC Health + Hospitals/Queens began its TV-replacement journey, it had been using an analog, low-definition satellite TV feed and distributing it to old, CRT-style ("tube") televisions in patient rooms. The quality was poor, unreliable and a source of complaints from patients and their families. Today, the hospital has a network of about 250 high-definition smart TVs integrated to communicate over the facility's existing coaxial cable infrastructure. The new TVs run patient-engagement software from one of the hospital's vendor partners, creating a hotel-style environment for patients. The hospital can now offer patients important educational information while continually enhancing the patient experience through new technology.

The vendor also has programmed an intuitive, tiled home screen on each of the TVs that gives users access to TV content; hospital information, such as pharmacy hours; a set of programmable preferences; and a catalog of patient

education. These smart TVs interface with the hospital's admission, discharge and transfer system to identify who is in each room. They communicate back and forth with nurses' station computers, enabling staff to assign appropriate content to each patient and monitor whether they watch it. The system features a library of more than 500 videos in English and Spanish, as well as with closed captions.

One of the highlights of this new TV system is its flexibility in allowing NYC Health + Hospitals/Queens to produce its own videos catering to patients. In the past, information would be given to patients as they were leaving the hospital. With the new interactive system, staff can start educating patients much earlier. We can assign videos based on their prognosis, including content that helps reinforce prescribed treatment or medications. There are even videos to help anxious patients relax.

Improved Care

NYC Health + Hospitals/Queens' nursing staff members have embraced the interactive system, recognizing its ability to assist with delivering improved care to more patients. The hospital's HCAHPS satisfaction scores have already begun to advance since the smart TVs were implemented in fall 2020, with early indications demonstrating that patients use and enjoy the new system, and nurses know that people are getting the health education they need. For instance, the organization had its highest score in the past two years on six of the 10 inpatient questions/domains. Ultimately, nurses can spend more time treating patients

and less time reviewing the important information now offered through the system.

“The overall system is working very well so far,” says Marveta Rios, RN, assistant director of nursing, who oversees the active, 33-bed medical-surgical inpatient unit. “Nurses can actually inform and guide patients with specific conditions by using these smart TVs. We’ve used this system to help patients with conditions such as diabetes, chronic obstructive pulmonary disease, pneumonia and pain management. A nurse will go to patients’ rooms and use the smart TV to pull up a brief educational video with information that will help them. Patients seem to love it, and the feedback has been very positive.” NYC Health + Hospitals/Queens has already begun making further improvements to the smart TV

system. Plans are underway to integrate it with the hospital’s EHR to allow nurses to select and assign patient videos directly from the patient’s electronic record, making the process faster and more convenient for the nursing staff.

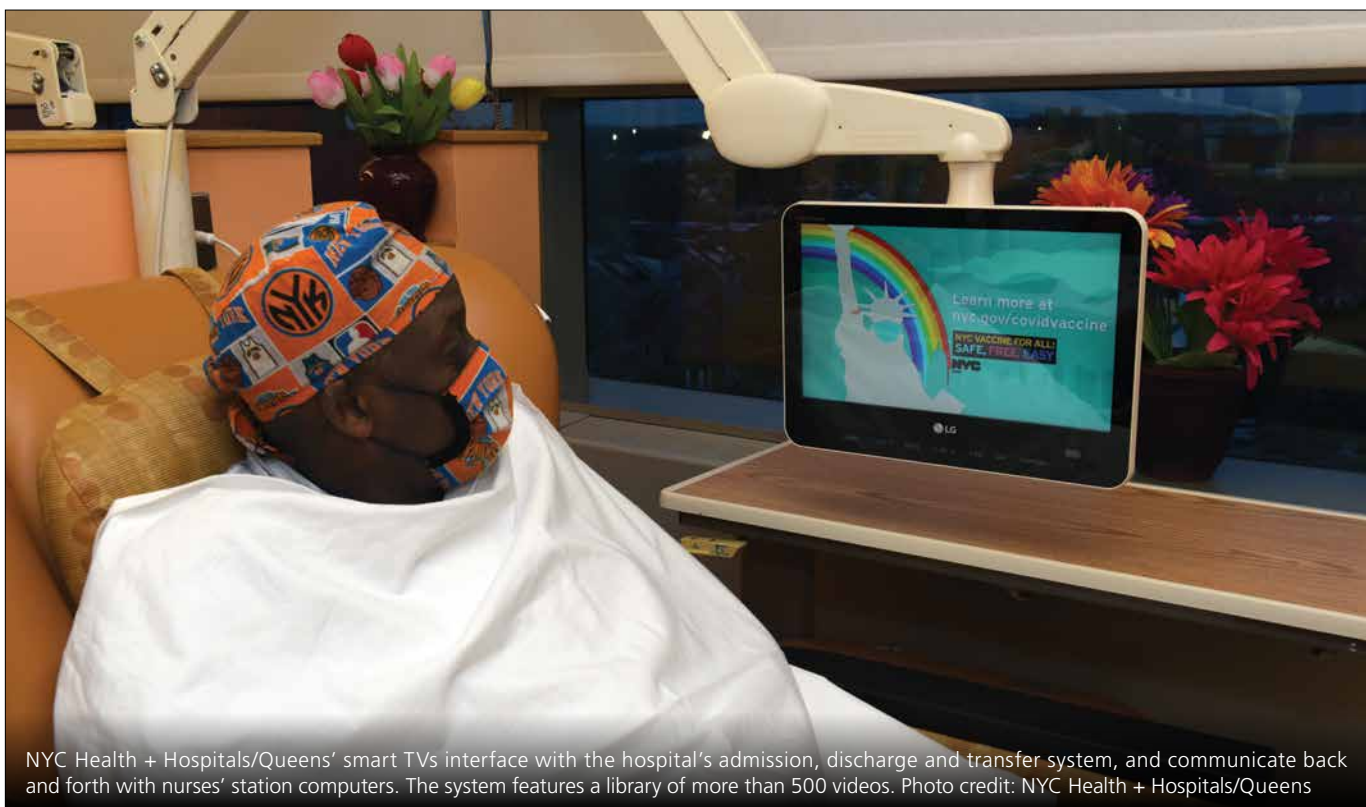
Merging Technology With a Human Touch

In its ongoing quest to become a truly person-centered healthcare facility, NYC Health + Hospitals/Queens recently has embarked on a journey to become Planetree-certified. A patient founded the Planetree healthcare model in 1978 as a way of restoring a greater sense of compassion and partnership in the caregiving process. The organization is committed to enhancing healthcare from the patient’s perspective. Delivering person-centered care involves caring for

patients beyond their condition and tailoring the hospital’s service to suit patients’ individual needs. It’s about respecting them and their individual priorities and collaborating with them to determine the best course of action in their treatment.

To achieve Planetree certification, NYC Health + Hospitals/Queens will strive to marry new technology with the human touch in everything it does. The system will work to engage staff to become patient advocates: to put themselves in the patient’s shoes and employ more empathy and sensitivity in all they do. The seeds have already been sown to ensure the hospital will meet this challenge. ▲

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NYC Health + Hospitals/Queens’ smart TVs interface with the hospital’s admission, discharge and transfer system, and communicate back and forth with nurses’ station computers. The system features a library of more than 500 videos. Photo credit: NYC Health + Hospitals/Queens



Ashish D. Parikh, MD



Jamie L. Reedy, MD

Using Analytics to Drive Improvement

Transitional care program has been a success at Summit Health.

Summit Health is a physician-led ambulatory care network with over 1,900 providers in 220 locations in New York and New Jersey, with an additional 150 providers in six locations in central Oregon. As an accountable care organization that adopted the value-based model of care more than 10 years ago, Summit Health regularly relies on data to develop programs that drive improvement in clinical and cost outcomes. This journey in taking on increased risk and larger patient populations represents a continuous learning process of approaches that improve care outcomes and lower costs. One example is Summit Health's transitional care management program.

Data Delivers Value

Begun in 2013, the program has been instrumental in reducing readmission rates for Summit Health patients at all levels of risk. For example, the readmission rate for Summit Health's Medicare patient population runs between 10% and 14%. This is much lower than the 18% to 20% readmission rate for the same population nationally. The readmission rate for Summit Health

Medicare Advantage patients is even lower, at between 8% and 9%.

Such results in reducing readmissions have been powered by regular, robust data and effective analytics that "tell" clinicians which patients should be receiving follow-up care and when. Data, in fact, was instrumental to the startup of the TCM program. When the program began, Summit Health realized claims data from health plans could be leveraged to identify patients at risk for readmissions. A patient's need for follow-up care after discharge could be stratified based on level of risk, the type of necessary care could then be identified, and outreach would be provided to these patients, reducing the potential for a return to the hospital.

How the Model Works

Three key elements are fundamental to the program: technology, people and processes.

Technology. Data got the program started, and it continues to be essential. The TCM program relies heavily on real-time data reporting on Summit patients that comes from multiple sources. In addition to daily census reports from health plans, Summit Health receives data on patient admissions, discharges and transfers from health information exchanges, such as the New Jersey Health Information

Network, which covers hospitals throughout the state, and Patient Ping, a national care collaboration platform that delivers real-time admission, discharge and transfer notifications.

The data feeds include information from across the medical neighborhood, including admissions and discharges from EDs, hospitals, acute rehabilitation facilities, skilled nursing facilities and home care agencies. The robust data analytics platform provides information that is used to stratify these patients into high, medium and low risk for readmission.

People. The TCM program includes a centralized team of more than 30 nurse care managers and social workers supported by medical assistants and non-clinical patient care navigators.

Processes. Key components of the program include constant monitoring for discharge alerts, tracking where Summit Health patients are and assessing their risk for readmission. The centralized team monitors the data feeds throughout the day to proactively identify patients requiring transitional care management services. The team reviews discharge summaries from the hospitals that outline the patient's plan of care post-discharge. They then determine whether the patient requires follow-up appointments with a primary



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care provider, a specialty provider or both, and the appropriate time frame for the appointment.

When a patient is at high risk of readmission, the goal is to schedule a follow-up with the treating physicians within 48 to 72 hours of discharge. For patients at a lower risk for readmission, the time frame is five to seven days after discharge. The program's nurse care managers use data to drive their decisions and find open appointments with the physicians. The care managers then determine the necessary type of follow-up care and reach out to the patients to schedule that care.

Reaping the Rewards

Analysis reveals the transitional care management program has reduced readmissions for all risk levels at 30 and 90 days after discharge but particularly for highest-risk patients. This has resulted in a lower total cost of care, even for low-risk patients, which means the program's impact goes beyond reducing readmissions.

Although the data demonstrates that those patients who aren't readmitted often have a higher spend on home healthcare and outpatient utilization, higher utilization of these ambulatory services leads to reduced total medical expense at all levels of risk. In 2020, for example, total cost of care was reduced by almost \$4,000 per patient in the highest risk category and by \$1,000 for those in the low-risk category during the 30-day period post-discharge. Higher ambulatory spend on physician services results in improved fee-for-service revenue as well.

Yes, Gaps Persist

Although this data-driven approach to reducing readmissions has proved

effective, the program is not foolproof. Early on, challenges included finding time in physicians' schedules for open appointments. Summit Health hired and trained more advanced practice nurses to work in PCP offices to support those physicians who have the largest patient panels. This enabled the nurses to examine low-risk patients and freed up access to the physicians for more complex care. Now, all primary care physicians have several appointment times reserved for patients in the transitional care management program each week.

Tracking patients has been another ongoing challenge. An unexpected finding was that the overall percentage of TCM completion rates was surprisingly low. Although there was a positive impact for those patients who were in the program, the surprise was that many patients were still not receiving transitional care management services.

This is because the health information exchange data doesn't cover admissions and discharges for all hospitals where Summit Health patients receive care. A patient may live in a second state and be admitted to a hospital in that state that is not currently participating in one of the exchanges used in the transitional care management program. Consequently, Summit Health's care team is not aware that these patients have been admitted and need transitional care services.

Then, there's the patient factor. Patients don't always follow through on the necessary steps such as complying with follow-up provider appointments. Some patients want to limit doctor's visits, so they might visit the cardiologist for heart failure care but won't go to their primary

care physician to manage their other conditions. The goal within the program is to make sure post-discharge care is comprehensive and that the PCP is looking at all of a patient's conditions, medications and risk factors for readmission.

These gaps demonstrated the need to double down on technology, people and processes to make sure the program can capture more Summit Health patients that have been discharged so they receive the appropriate follow-up care. It may be impossible to track 100% of Summit Health patients, but the growing level of connectivity in the healthcare industry and stronger partnerships with health plans have enabled the use of more regular data.

Choosing the Right Way

Perhaps, fundamentally, the basis for such strong results with the TCM program has been Summit Health's ability to anticipate the requirements and measures that indicate exemplary patient care. The TCM program positively impacts the two claims-based measures—admission rates for patients with two or more chronic conditions and all-cause 30-day readmission rates—that the Centers for Medicare & Medicaid Services chose to use as measures of success for ACOs. What this proves is that what seems so easy to fathom, yet deceptively complex to achieve, is that if healthcare organizations choose to do the right thing, patient care outcomes will improve, costs will decrease and revenues will improve. ▲

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Paul H. Keckley, PhD

Alternative Payment Models: Changes Ahead

CMS signals four paths forward for APMs.

When the Affordable Care Act was enacted in 2010, alternative payment models were introduced as a means of lowering Medicare costs while improving efficiency and quality. The Centers for Medicare & Medicaid Services created its Center for Medicare & Medicaid Innovation to coordinate these efforts.

Initially, Congress authorized 27 potential models in CMMI's statute; each would run for three to five years and would be extended or expanded if found to decrease spending without reducing the quality of care or increasing quality but not spending. The exception was the Medicare Shared Savings Program, which is permanent and under the direct oversight of CMS. Through the MSSP, providers and suppliers can voluntarily create an accountable care organization that can be held accountable for the quality, cost and experience of care of an assigned Medicare fee-for-service beneficiary population.

Generally, APMs fall into two categories: population-based models that require accountability for overall quality and costs for defined patient populations and episode-based payment models that emphasize accountability for quality and costs for discrete care. Participation has been voluntary, and changes to

benchmarks for calculating savings and the designation of measures of quality have been routine.

APMs have successfully attracted provider participation, but results for most models have been disappointing.

To encourage physician participation, the Medicare Access and CHIP Reauthorization Act of 2015 created the Quality Payment Program. It allows physicians and other providers to participate through one of two tracks: the Merit Based Incentive Payment System, in which physicians can earn performance bonuses of 1%–2%, or advanced APMs, which involve higher risk and the potential to earn 5% from shared savings and require participants to use EHRs.

Over the years, CMMI expanded its focus to 54 APMs from 27, including four added in 2020: the Part D Senior Savings model; the Geographic Direct Contracting model; the Direct Contracting Duals model; and the Community Health Access and Rural Transformation model. However, many of these models have been suspended.

Currently, CMMI operates 12 APMs, offering 25 tracks for providers involving different payment options and risk arrangements. More than 800,000 physicians participate, and more than 12 million Medicare enrollees are engaged through one or more APMs or the MSSP.

Mixed Results to Date

In January 2021, Brad Smith, director of CMMI at the time, wrote an analysis of the Innovation Center's progress and lessons learned over 10 years in the *New England Journal of Medicine*. "The Center's models have ... delivered some positive, tangible results, including five that have resulted in substantial financial savings. Several models have also produced significant improvements in quality. ... However, the vast majority of the Center's models have not saved money, with several on pace to lose billions of dollars. Similarly, the majority of models do not show significant improvements in quality, although no models show a significant decrease in quality."

Similarly, an article published in the April 2020 volume of the *Annual Review of Public Health* concluded that APMs "have been associated with modest reductions in Medicare spending without apparent compromises in quality. However, concerns about the unintended consequences of these APMs remain, and more work is needed in several important areas. Nonetheless [APMs] represent steps to build on along the path toward a higher-value national health care system."

Likewise, the ACOs within the MSSP have also had mixed success

since the program's creation in 2013; in its early years, savings to Medicare were negated by shared savings payments to provider participants. In its June 2019 report to Congress, which included an analysis of the MSSP's first four years, the Medicare Payment Advisory Commission found that Medicare spending growth slowed by 1%–2% over those four years (the equivalent of 0.25%–0.5% gross savings per year) but net savings were not calculated.

APMs and the MSSP are here to stay, but requirements for participation, and success in managing financial and clinical risks, will change.

More recently, however, CMS reported in August 2021 that the ACOs participating in the MSSP in 2020 “earned performance payments (shared savings) totaling nearly \$2.3 billion while saving Medicare approximately \$1.9 billion, marking the fourth consecutive year of net savings for Medicare.” Commenting on these results, CMS Administrator Chiquita Brooks-LaSure called ACOs “an Affordable Care Act success story” and indicated they will continue to play a key role in the agency’s APM strategy while allowing that changes in benchmarking, patient attribution and savings calculations will be made.

Future Direction for APMs

APMs have successfully attracted provider participation, but results for most models have been disappointing. CMMI has not specified its plans for its APMs, and CMS has not updated guidance about the MSSP

program. But both have sent clear signals about the direction they’re pursuing:

Fewer, simpler models. In its June 2021 report to Congress, MedPAC recommended that “The Secretary should implement a more harmonized portfolio of fewer alternative payment models that are designed to work together to support the strategic objectives of reducing spending and improving quality.” That suggests fewer models, standardized measures for quality and efficiency, reduction of overlapping participation, higher financial risks, models targeted to at-risk populations (i.e., dual eligibles) and rewards for participants, and added emphasis on patient access and experiences, especially in ethnic and income cohorts that face unusual challenges.

Mandatory participation. To enhance data gathering and facilitate standardization, many APMs will be mandatory, particularly bundled payment models like the Comprehensive Care for Joint Replacement model and radiation oncology models.

Closer scrutiny of business partners. CMS and its Innovation Center will intensify oversight of business partners’ roles in assisting APM provider participants. A particular focus will be governance structures controlled by clinicians and profit-sharing arrangements between the business partner (i.e., a hospital, health plan or outside operator) and providers.

Expansion to Medicaid and commercial payers. CMS and CMMI will encourage private insurers, Medicaid and large employers to

adopt APMs as a means of accelerating the transition from fee-for-service to value-based payments.

APMs and the MSSP are here to stay, but requirements for participation, and success in managing financial and clinical risks, will change. They are Medicare’s bridge from fee-for-service to value in the U.S. healthcare system’s complicated approach to compensating its providers.

Every healthcare organization should evaluate its participation in APMs and MSSP models with these four likely changes in mind. ▲

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Helene Burns, DNP, RN, NE-BC



Autum Shingler-Nace, DNP, RN, NE-BC

Building Authentic Leadership and Trust

They're essential competencies for leaders now and in the future.

The COVID-19 pandemic has been a catalyst for innovation and collaboration. Throughout the pandemic, we identified seven phases that, in our experience, were improved through the core leadership competencies of trust and authenticity.

Employees tend to trust leaders when they feel they are interacting with the real leader (authenticity).

In many instances, leadership focuses on the leader: his or her vision, strategy, charisma, courage and instinct. To fully maximize leadership's effectiveness also involves how others react to the leader and his or her ability to empower. In their May–June 2020 *Harvard Business Review* article “Begin With Trust,” Frances X. Frei and Anne Morriss describe three core drivers of trust: authenticity, logic and empathy. Employees tend to trust leaders when they believe they are interacting with the real

leader (authenticity). When trust is lost, it often can be traced back to a breakdown in one of the core drivers. This article will focus on the importance trust and authenticity have played in leadership throughout seven phases of the pandemic and the value of using these tactics to assist leaders during challenging times in the future.

Phase 1: Fear

Fear can amplify weaknesses that exist in relationships. When our institute diagnosed its first COVID-19 patient, the unknown caused increased fear: Staff were afraid, they watched many patients die, and they certainly watched us as leaders and how we reacted to each new situation we encountered.


Staff wanted to trust the process, and trust leadership's guidance, but when protocols changed often, it created more fear. Authenticity and transparency from leaders helped build trust during this chaotic and informative time. This meant leaders had to be vulnerable, empathic and honest—even when answers were unknown. The leadership team did this by focusing on validating concerns and listening not only with their ears but also with their brain, eyes and heart.

Phase 2: Innovation

Technology became a primary tactic for most organizations during the pandemic. Authentic leaders involve followers in decision-making and change and empower them to have a voice. The leadership team empowered staff, through multiple forums, to allow open communication and build trusting relationships. Town halls, weekly huddles and routine rounding were all ways that assisted with visibility and two-way communication. It was extremely important to ensure leaders were aligned when they were making innovative decisions and that, during each interaction, communication was consistent no matter who the leader was. It was also critical for leaders to encourage buy-in from front-line staff and explain the “why” behind decisions, which helped staff feel more like partners in decision-making and allowed them to better understand the importance of any changes taking place.

Phase 3: Acknowledgement and Recognition

As the journey continued through the pandemic, there was social support, public support and media support for front-line workers. Recognizing excellence in employees is beneficial in many ways; however, this pandemic has underscored that



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recognition should be purposeful and meaningful if leaders want to build trust with staff members. In our experience, recognition seems to have its biggest impact on trust when it occurs quickly, when it's tangible or public, when it's personal, and when it is unexpected. Staff were—and are—seemingly grateful and more engaged when they feel valued. Individuals were celebrated in town halls, letters from the president, communications from the board, at manager meetings, and at scheduled and surprise award ceremonies.

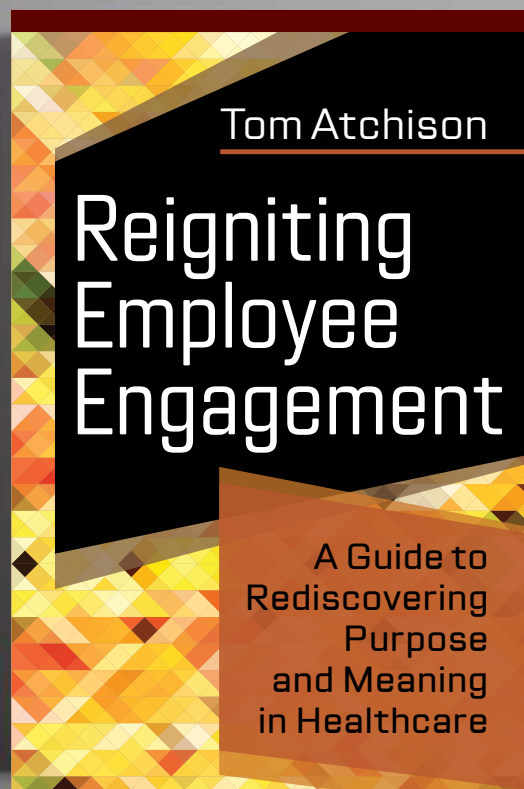
Phase 4: Anger and Frustration

Eventually external support for front-line workers declined, frustration from lockdowns grew and workforces were reduced to manage future stability. This trend impacted the morale and the commitment of some front-line staff, making it a challenge to maintain an engaged workforce.

Throughout the organization, leaders had to help employees and front-line staff, who had just endured the most trying times of their career, understand the thinking behind extremely difficult decisions. When leaders made the message relatable and connected the dots for employees, it helped them navigate through complex information and assisted them with processing their feelings. For example, our leaders developed road maps that helped staff understand how their role could play a pivotal part in meeting the overall goals that were established.

Phase 5: Apathy and Exhaustion

By this phase, some areas of the country were experiencing a second wave of the pandemic and staff seemed defeated. It became increasingly more



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difficult to collaborate with front-line teams. So how did leadership get them to become engaged?

Although the pandemic certainly presented many obstacles, it also helped identify opportunities and ultimately refocused leaders on the importance of the key competencies of authentic leadership and trust.

Listening sessions were scheduled with individual departments on a rotating basis. Leadership made this a priority, our staff showed up and our leaders listened. They were authentic and

empathetic. The listening sessions had no formal agenda; they were designed solely for leaders to listen to staff and their concerns. The popularity of the sessions grew, and staff began to look forward to them. The sessions were a big commitment from the leadership team; however, the more routine they became, the more the staff were engaged. Two-way communication was reinstated, and a “we’re in this together” mentality was reborn.

Phase 6: Hope

Vaccines were the main focus during this phase. After months of frustration, sadness, anger and apathy, there was finally hope. But with hope also came more questions: Who will get the vaccine first? How long will the vaccine last? Will the vaccine be mandated?

One of the biggest challenges to building trust during this phase was transparency. Ethical considerations on the tiered approach of how vaccines were delivered (in order) made some staff feel highly valued, while other staff again felt defeated in the ranks. Staff that felt devalued became less engaged and more frustrated. Leaders again needed to demonstrate respect, create transparency, confront reality, listen first, and, probably most important in this phase, right wrongs (adapted from *The 13 Behaviors of a High Trust Leader* by Stephen M.R. Covey).

Leaders continued to infuse hope throughout the organization, and focusing on positivity became a priority. Leaders were able to begin to shift the culture to a hopeful atmosphere

by sharing positive outcomes and success stories of the many COVID-19 patients who received excellent care, modifying COVID-19 restrictions, as vaccinations were provided, to meet safety guidelines and return to a sense of “normal,” and bringing the fun back through outdoor events such as celebrations and gatherings within state safety guidelines.

Phase 7: Unknown

Today we ask, what will be next? What long-term physical and mental effects will develop among our staff members related to COVID-19? It will be imperative for leaders to recognize these situations early and protect their staff through appropriate measures. To be truly empowering, leaders need to take stock of where their

opportunities lie not only in relationships with others but also in the relationship with themselves. To improve on their ability to be relatable and connect with staff, it is important for leaders to seek feedback and ask others to help them identify blind spots. Leaders can do this through a formal peer review process, such as 360 evaluations. Having formal and informal avenues to receive feedback is helpful to understand areas for growth and opportunities to improve.

Focus on the Future

Although the pandemic certainly presented many obstacles, it also helped identify opportunities and ultimately refocused leaders on the importance of the key competencies of authentic leadership and trust.

One could argue that the expectations during this time were unimaginable, unpredictable and, at times, unfair. However, this pandemic experience so far has shown how with effective planning and partnership between front-line staff and leadership, there is the potential to develop strong strategies for improvement in relationships and successful outcomes for the future. ▲

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Pamela R. Knecht

Increasing the Board's Strategic Dialogue

Best practices and techniques to encourage important discussion time.

Every board wants to spend more time in strategic discussions. And yet, only 29% of board meeting time is spent in active discussion, deliberation and debate about the organization's strategic priorities, according to The Governance Institute's *2021 Biennial Survey of Hospitals and Healthcare Systems*. The Governance Institute also notes "there has not been significant movement in this area since 2005."

This situation is concerning because The Governance Institute states, "several prior surveys have shown a positive correlation for all organization types between spending more than half of the board meeting time (over 50%) discussing strategic issues and respondents rating overall board performance as 'excellent.'" Despite the evidence that strategic dialogue increases the board's overall

performance, the field has been unable to move the needle on this issue for over 15 years.

Techniques for Improved Strategic Discussions

Boards need to address legal, regulatory, financial and quality issues, as well as improve the community's health (see sidebar below for more information on these important

Other Important Board Topics

Although it is important that boards significantly increase their strategic dialogue, they also need to ensure robust discussions are held about the following essential topics.

Addressing legal and regulatory requirements.

Hospital and health system boards must meet legal and regulatory requirements of The Joint Commission, the Office of the Inspector General, the Internal Revenue Service and other regulators; therefore, boards must take time to credential providers, approve the annual audit and compliance plans and manage conflicts of interest, among other tasks.

Ensuring financial stability. Healthcare reimbursement has always been complex, and the move from volume to value during the pandemic has added to the challenge of remaining financially viable. Boards need to carefully review management's recommended budgets and capital plans to ensure sustainability.

Overseeing high-quality safety and service. Providing high-quality clinical care, patient safety and patient experience is part of the mission of most healthcare organizations. This is especially important in this era of consumerism where patients can view data from healthcare ratings and reports and choose a competitor for their care. It makes sense for boards to focus on quality, safety and service.

Improving the community's health. Hospital and health system boards are ultimately responsible for meeting the health needs of the communities they serve. Therefore, boards should spend time understanding the social determinants of health of these communities and advocating for the underserved.

topics). However, using the following methods will help boards shift more of their meeting time to the strategic discussions that are essential to stellar board and organizational performance.

Decreasing time reviewing reports.

One of the main culprits “stealing” board discussion time is reviewing reports. Too many boards and executives have fallen into the habit of allowing management and committees to give verbal reports of information in the board packet. Some board members argue that listening to reports provides needed education and information. However, high-performing boards realize that allowing that practice to continue wastes time that could be better spent on important discussions.

Boards that are determined to decrease reporting and increase time for dialogue institute the following practices:

- Using an easy-to-navigate board portal.
- Ensuring packets are available at least one week before each meeting.
- Insisting packet materials include governance-level, graphically displayed information.
- Including as much as possible in a consent agenda.
- Including a written CEO report in the packet.
- Revisiting the sequencing of committee meetings to allow time to prepare reports.
- Requiring one-page summaries of committee and executive “asks” of the board.
- Eliminating verbal presentations of packet materials and committee reports.

- Storing minutes on the portal for reference versus including them in the packet.
- Trusting the work of the committees.

Teeing up discussion, deliberation and debate.

The aforementioned practices can free up time for discussion. However, the challenge for most chairs and CEOs is how to tee up active deliberation of issues. That takes vision, planning, time and a strong chair-CEO partnership.

.....
Despite the evidence that strategic dialogue increases the board’s overall performance, the field has been unable to move the needle on this issue for over 15 years.
.....

The best chair-CEO teams use the following techniques to tee up dialogue:

- Creating an annual board calendar with two to three strategic topics per meeting based on the strategic plan and the board education plan.
- Identifying priority discussion topics for the next board meeting (e.g., holding preparatory meetings with the chair and CEO, and separate meetings with committee chairs and staff liaisons).
- Providing education on upcoming strategic issues.
- Constructing agendas with clear times, expected actions (approve, provide input) and a crosswalk to the strategic plan initiative(s) related to each agenda topic.

- Providing framing questions for each major agenda item to clarify what management needs the board to discuss (e.g., What are the pros and cons of expanding our service area to include X counties?).
- Ensuring meeting slides are high-level summaries that include the framing question(s).

Creating a culture of robust, facilitated discussions.

The key to increasing strategic dialogue is to create a board culture in which members are expected to study the materials, come prepared with specific questions and suggestions, and speak up in the meeting. To help them, it is incumbent on the CEO and other executives to do the hard work of summarizing key information and clarifying exactly what advice and approvals they would like from the board. Senior leaders may also need to suppress the desire to present and, instead, focus on asking specific questions designed to engage board members in two-way conversation.

It is ultimately up to the chair to ensure the board materials set the stage for lively debate and to facilitate discussions that engage all board members in dialogue about important strategic topics. In this way, boards can become invaluable resources during these challenging but transformational times. ▲

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Editor’s note: The “Governance Insights” column in the March/April 2022 issue of *Healthcare Executive* will include more findings from The Governance Institute’s 2021 *Biennial Survey of Hospitals and Healthcare Systems*.



Kedar Mate, MD

Addressing Pushback on Health Equity

Leaders can harness curiosity as an antidote to fear and resistance.

Though health equity is now in the consciousness of healthcare leaders in a way that we have never seen before, this shift presents both risks and opportunities. One risk is missing opportunities for change because they may be hard to face. As we measure disparities, we will almost certainly uncover some difficult truths.

Just as important as data are stories from those who have experienced inequities. These stories are crucial to any effort to improve equity.

But with adequate coaching and support for changing practices and behaviors, clinicians and health systems will be less likely to fall into defensive postures and more willing to accept and support data showing disparities in how patients receive and experience care and in their health outcomes.

As we move forward to achieve more equitable health and care, we also have the opportunity to learn from the beginnings of the patient safety movement.

Don't Fear Pushback: Expect It and Prepare for It

In the spring of 2019, only 25% of U.S.-based healthcare leaders surveyed by the Institute for Healthcare Improvement identified health equity as one of their organization's top three priorities. In another IHI survey in the summer of 2021, the percentage of healthcare leaders naming health equity as one of their organization's top priorities more than doubled to 58%. This increasing focus on health equity is a significant, and encouraging, step toward closing equity gaps in health and healthcare.

Yet, IHI colleagues and partners who have been working on these gaps for years note that this increased focus will simultaneously increase something else: pushback. All change prompts some pushback, and for a change as crucially important as this, effectively addressing pushback is a key responsibility for healthcare leaders.

Pushback against efforts to close equity gaps takes many forms. IHI's partners at a community health center in Boston compiled a list of concerns they've heard repeatedly, including statements like the following: "That doctor doesn't have a racist bone in his body." "This will cost

too much." "As soon as you talk about race, you turn people off." "Race is not a problem here. It's [something else]."

Healthcare leaders can effectively prepare for and address pushback related to health equity improvement efforts by taking three key steps.

1. Expect and prepare for pushback.

If you're not getting pushback, something's probably not quite right about your strategy. Working on equity and racism is not easy. It's deep. It's personal. It's contentious. It's in the public eye, as much as it is in the private sphere. If you're not getting some form of resistance, then you're probably not expressing your intent explicitly enough or setting your goals high enough. Don't fear resistance; expect it and prepare for it.

2. Address pushback with data and stories.

Don't get too abstract or too complicated. Equity is a local issue. It's relevant to your organization, your town, your city, your department, your unit.

For example, I remember when my hospital department proposed looking at racial differences in discharging patients on pain controllers at the end of a hospital stay. Staff in the department didn't expect to find any differences. They said things such as, "We treat everyone the same. There's no systemic difference in how we treat our patients." It was typical pushback. We agreed to gather the data and then come back together for a second conversation.

The data showed a systematic difference and a clear disparity between

Black and white patients with similar pain scores at discharge: Clinicians were less likely to prescribe more powerful pain medications at discharge to Black patients than to white patients.

That data transformed the resistance met after the first discussion into curiosity by department staff. Curiosity is the antidote to fear and resistance, and it is essential because it leverages the strengths in every provider—the desire to help, to heal, to treat everyone fairly—to remove inequities made clear and undeniable by the data.

Just as important as data are stories from those who have experienced inequities. These stories are crucial to any effort to improve equity. For some, stories can be even more impactful than numbers in transforming pushback into curiosity; that curiosity can then be harnessed to gather more stories and more perspectives. It's not easy to try to see your work through someone else's eyes. So, rather than trying to imagine what it felt like for a patient, find out. Ask them.

Directly engaging those with lived experience of racism and inequities is a necessary step in both fully understanding the scale of the problem and in co-designing effective solutions with them.

3. Gain a deeper understanding of what is driving pushback. Fear is often the emotion that drives resistance to seeing and eliminating inequities. It's not uncommon to be afraid of confronting these issues, both personally and organizationally. It's the responsibility of

leaders, however, to create environments that limit this natural fear and explicitly prohibit blaming and shaming. Racism and inequities in healthcare need to be understood as system properties, not merely the product of individual actions and prejudices. While it's important to have zero-tolerance policies for overt individual instances of racism, collectively addressing inequities needs to happen at the system level.

.....
With adequate coaching and support for changing practices and behaviors, clinicians and health systems will be more willing to accept and support data showing disparities in how patients receive and experience care and in their health outcomes.
.....

Learning From the Patient Safety Movement

Courage, curiosity, data, stories, and overcoming fear all are essential to another key area of improvement in healthcare: patient safety. The parallels between the early days of confronting pushback on patient safety issues to our present moment of confronting inequities are striking. This is encouraging, not only because of the strides we've made in improving safety over the years but also because we now have many of the necessary tools and experiences to help prepare us for pushback on closing equity gaps.

Throughout the patient safety movement, the most resistant members of the clinical community or the administrative community often became the most ardent advocates for change. Passionate, exuberant resistance is frequently a symptom of caring very deeply about an issue. When you meet that ardent resistance with well-prepared data and stories, moments of "transformation" can occur.

People talk about transformation a lot; it is created in two ways: First, find the most active resistor and share the data and the stories of those who have suffered senselessly from the heavy hand of racism and inequity.

These lessons—learned in the patient safety movement—can help us move further and faster in our effort to remove inequities.

Second, when preparing to effectively address pushback, it is helpful to remember that the healing professions have shared values, or at least a shared commitment to heal. We share the desire to treat people equitably and to ensure that everyone has an opportunity to succeed and thrive. We share the belief that trust matters and that people matter. This shared foundation is essential.

Start with those shared values because they provide the basis on which to grow relationships, and relationships will allow you to address pushback with real information that shows the path to a different and better future. ▲

Kedar Mate, MD, is president/CEO of the Institute for Healthcare Improvement (kmate@ihi.org).



Kenneth P. Jones, FACHE

Consistency in Leadership Is Key

It unites an organization’s culture, behaviors and strategy.

If there has been one constant theme for healthcare workers worldwide—whether they are front-line caregivers, ancillary staff, first responders or leaders—it’s undoubtedly change. We’ve all likely heard the words, “nimble,” “resilient” and “unprecedented” more during the last two years than ever before, and they have become a directive in the hospital setting. Being faced with a novel, dynamic pandemic that continues to evolve over time can often feel defeating and has been a tremendous driver of burnout. Just when it feels like we’ve finally wrapped our arms around the situation before us, we watch as it shifts once more and we have new pieces of the puzzle to put together.

In today’s environment, many of us are facing significant workforce challenges. This begs the questions most leaders are currently asking themselves: In the midst of almost certain change, how can we establish a united front and a clear direction and build a strategy that works? What gets us out of bed in the morning with a renewed resolve to tackle the same obstacles that keep us up at night and inspires others to do the same? All of this boils down to consistency, which is the common thread that ties together an organization’s culture, behaviors and how it plans for the future.

Cultural Alignment

Without consistency there can be no recognizable culture to align an organization. Arguably, once that solid foundation is built, everything else should begin to fall into place. Particularly in a hospital environment, there are many stakeholders and moving parts that all must come together as one multidisciplinary team to deliver safe and high-quality care to the patients we serve. As leaders, we have a responsibility to unite all of these stakeholders and interests under one common mission and set of values to foster engagement and build a sense of belonging.

In the case of Northwest Medical Center, which is an affiliate hospital of HCA Healthcare, its mission is clear and unwavering: a commitment to the care and improvement of human life. Its values of accountability, leadership, willingness, attitude, “you first” and safety all ladder up to that mission.

Regardless of what is happening within the organization at any given time—even during unanticipated changes—Northwest is grounded by the shared understanding that everything it does should serve that higher purpose put forth by HCA Healthcare. In

other words, this is the “why” we do what we do and the driver that should remind us why we keep going each day.

To make a meaningful impact as a leader, your team needs to trust that when it comes down to it, you mean what you say and you won’t waver in your commitments.

Behavioral Consistency

To support that culture and shared mission and vision, leaders must set the standard of consistency in their behaviors if they hope to achieve excellence. A period of change such as this pandemic should not ultimately change what we set out to do each day, even if it forces some changes in the strategies and tactics we employ to do it. Day to day, your organization may need to remain flexible and try out innovative, creative solutions to solve for new challenges.

Our behaviors might appear at the micro level as if they are constantly changing, but looking at the bigger picture, everyone fundamentally understands what is expected of them and what part they play in the organization’s success as a whole. Every behavior or action we take on behalf of our organization should be representative of our overarching mission and set of core values and everyone, regardless of their role within the organization, should be held to that same standard.

Consistency is also necessary for building trust and credibility both within the organization and out in the communities we serve. This rings true in the midst of a public health crisis, when our own colleagues and our patients turn to us for answers and for expert care. If a patient has visited your hospital in the past and had a positive experience, you would want them to be able to rely on that same standard of care each time they are in your care, or if they move from one unit or department to another during the same visit. They are not likely to entrust their care or that of their loved ones to your facility if they're never quite sure what level of quality and service they are going to get.

Similarly, in an internal capacity, it is difficult to build relationships and engage your team if you don't lead with transparency, and if every decision you make doesn't align with the standards you've set. To make a meaningful impact as a leader, your team needs to trust that when it comes down to it, you mean what you say and you won't waver in your commitments. They should be able to recognize that as a leader, the decisions you make that impact their work are made with the best interest of the organization and the team in mind.

Organizational Strategy

Though it may feel counterintuitive to plan for the future when you don't know what tomorrow might bring, consistency also has an important place in any organization's efforts to develop a strategic direction and determine what comes next. As with everything else, the best decisions that are

made to set up the organization for a future paved with success and growth will always have a clear connection back to that organization's mission and purpose. When you make capital investments in equipment or renovations, it's done with the shared understanding that the end goal is to better serve patients and deliver an excellent care experience. When you plan for expansions, strategic partnerships or new access points out in the communities you serve, you're building a future centered on making care more accessible and convenient for patients.

Culture runs deep; it is the backbone of any successful organization and should clearly explain what we do,

how we do it and why. It serves as a pillar of strength for teams who are navigating times of significant change, and even the unthinkable. The formation and ongoing maintenance of a culture is completely dependent on consistency at all levels, but it is up to leaders to set the tone for their organizations. With culture at the forefront, supported by consistency in standards, behaviors and decision-making, you can solve big problems; you can be excited about your work and the future because you know you are a part of something bigger; and, you can inspire your teams to get excited with you. ▲

Kenneth P. Jones, FACHE, is CEO, Northwest Medical Center, Margate, Fla. (kenneth.jones2@hcahealthcare.com).

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Do you know a healthcare management student who needs financial aid? ACHE is currently accepting applications for the Albert W. Dent and Foster G. McGaw graduate student scholarships until **March 31, 2022.**

For more information visit ache.org/Scholarships

Applicants will be notified in July.



Richard Priore, ScD,
FACHE



Michael Bernstein, MD

The Importance of Physician Alignment

A challenging yet critical leadership imperative.

Alignment is the degree of unity of purpose that results in a symbiotic and mutually beneficial relationship with physicians. The misalignment of financial incentives, which stems largely from the prevailing fee-for-service reimbursement model, can contribute to wide clinical practice variation and overuse, adding to rising healthcare costs.

It has also resulted in the perception that physicians, who were once considered heroes for driving more revenue, are threatening already-thin margins as payers increasingly move from volume-driven to value-based reimbursement.

A challenging yet critically important leadership imperative is to engage physicians in being champions and active participants in organizational performance improvement initiatives while also aligning their financial incentives.

Despite the importance of physician alignment, many organizations do not have a formal plan with clearly defined measures of success.

Although healthcare leaders understand the importance of a strong relationship with the physicians who practice at healthcare organizations, many struggle with choosing an effective alignment strategy from a variety of models, incentive structures and confounding regulations.

Recognizing its importance, it is critical for leaders to continuously measure and monitor how closely organizational performance aligns with its physician incentives.

Providence Alaska: Aligning for Success

Providence Alaska in Anchorage is the market leader with a reputation for high-quality, accessible care; however, leadership was concerned that the movement to value-based care could be incongruent with the perspectives and perceptions of its largely independent clinical staff. The future success of the system was anticipated to be mostly predicated on how tightly aligned it could be with its physicians.

Using an evidence-based physician alignment survey to quantify physicians' attitudes and beliefs, combined with extensive stakeholder interviews conducted by an external consultant, leadership identified and prioritized opportunities to tighten alignment with the clinical staff. "We have heard the collective physician voice request to be involved in Providence Alaska's processes, and the alignment survey is an important first step in understanding how to best accomplish that goal," says Preston Simmons, DSc, FACHE, the Alaska region CEO.

Scores on the 100-point scale within seven alignment domains were benchmarked with similar leading organizations. Key strategies identified included engaging physicians at all levels of the organization, sharing both clinical and financial performance measures, providing practical training and education, and offering at-risk compensation.

A seat and a say. Engaging physicians at all levels of leadership creates increased ownership and accountability. Cultivating a deep bench strength of physician leaders who can then serve in critical decision-making roles—from the boardroom to clinical service



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for a web extra on this topic.

lines—supports achieving and sustaining strategic goals.

Through the alignment assessment, the system's leaders identified several key opportunities to engage physicians in clinical, financial and operational venues that did not traditionally involve them.

Physicians were invited to participate in strategic planning, supply chain value analysis, data governance and financial planning committees. The transparent, inclusive and participative decision-making with physicians helped dispel existing sentiments of there being deal-making happening behind closed doors and fostered goodwill and trust among the clinical staff.

Integrated clinical and financial data. Physicians are scientists and rely on using timely, reasonably accurate and actionable data to inform their effective clinical decision-making.

The same is true for financial data. Physicians and other providers control or influence a significant portion of healthcare spending. They are the only ones who can admit or discharge a patient, order a test or drug, or perform a procedure; however, most are not apprised of the costs of their practice to improve both clinical efficacy and cost-efficiency.

In a randomized controlled study conducted at Johns Hopkins Hospital and published in *JAMA*

Internal Medicine, physicians who were given cost information for lab tests reduced their ordering of ostensibly unnecessary tests and cost without compromising clinical outcomes.

Physicians are often challenged with translating quality improvement needs into a defensible bottom line financial justification. Monetizing quality improvement efforts and connecting them to the anticipated financial impact with a measurable return on investment enables physicians to be more cognizant of the use of increasingly scarce resources.

At Providence Alaska, physicians are provided with quality and cost



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data and profiled against their peers to identify best internal practices. Relatively high-quality outcomes and low-cost physicians serve as a model for their colleagues.

Internal best practices benchmarked against both existing evidence-based knowledge and other high-performance hospitals are developed through physician-led multidisciplinary teams and implemented through well-documented clinical process redesign.

.....
Engaging physicians at all levels of leadership creates increased ownership and accountability.
.....

Relevant education and training. Although physicians significantly influence the total cost of care, they are not always trained in the business of healthcare. Thus, changing less effective and efficient clinical practice patterns is difficult and requires continuous support.

Providing physicians with organization-sponsored “how-to” training, education, and ongoing coaching and mentoring is a best practice to promote good financial stewardship that enables increasing investment in quality and safety programs.

For example, Providence Alaska offers transformation to value-based care workshops and how to develop and apply an effective business case for improving quality.

The goal of these workshops is to help support physicians’ integration of clinical and financial information into their decision-making. The integration of such information supports physicians’ promise to their patients of “first, do no harm,” but it also supports the organization’s financial goals. All physician leaders and new medical directors attend a series of physician leadership development courses that include topics such as financial management and value-based care.

“Skin in the game.” Creating deeper economic alignment opportunities with physicians by soliciting their suggestions on how to structure increasingly common pay-for-performance arrangements promotes buy-in and accountability for achieving the desired goals.

French philosopher Blaise Pascal is known for having said, “We are generally better persuaded by the reasons we discover ourselves than by those given to us by others.”

In fact, physicians are typically more supportive when involved with how the data used to grade their performance are collected and reported. What’s more, involving physicians provides a valuable opportunity to engage them throughout the performance improvement process.

The leadership at Providence Alaska have experimented with different compensation incentives, for both independent and employed physicians, mirroring increasingly common at-risk models offered by many commercial payers.

For example, surgeons are offered financial incentives to lower infection rates and total cost of care.

The organization also launched a clinically integrated network with a physician-led board to support the transition to value-based care. The physicians choose the performance measures that drive higher-value care for patients.

As research continues in the area of physician alignment, it is hoped that healthcare leaders will increasingly use an informed, evidence-based management approach with their clinical staff to improve organizational performance.

Recognizing its importance, it is critical for leaders to continuously measure and monitor how closely organizational performance aligns with its physician incentives.

Providence Alaska has experienced noteworthy improvements in lowering lengths of stay, reducing hospital-acquired infections and improving financial performance.

The organization’s leadership also anticipates significant improvement in its alignment score compared with the initial baseline, due to the substantive and measurable investments it has made with and for its physicians. ▲

Richard Priore, ScD, FACHE, is founder/president, Excelsior HealthCare Group, St. Paul, Minn. (rpriore@excelsiorhcg.com). Michael Bernstein, MD, is regional CMO, Providence Alaska, Anchorage (michael.bernstein@providence.org).



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ACHE MEMBER UPDATE

ACHE Announces Nominating Committee 2022 Slate

The ACHE Nominating Committee has selected a slate of leaders to be presented for approval at the Council of Regents Meeting, March 26. All nominees have been notified and have agreed to serve if elected. All terms begin at the close of the Council meeting in March. The 2022 slate is as follows:

Nominating Committee Member, District 1 (two-year term ending in 2024)

Christine C. Winn, FACHE
Senior Vice President, MD Anderson Cancer Center Institute and Physician Alignment
Cooper University Health Care
Camden, N.J.

Nominating Committee Member, District 4 (two-year term ending in 2024)

Todd A. Caliva, FACHE
CEO
HCA Houston Healthcare Clear Lake
Webster, Texas

Nominating Committee Member, District 5 (two-year term ending in 2024)

Jennifer D. Alderfer, FACHE
President
SCL Health/Good Samaritan Medical Center
Lafayette, Colo.

Governor (three-year term ending in 2025)

Noel J. Cardenas, FACHE
Senior Vice President/CEO
Memorial Hermann Southeast and Pearland Hospitals
Houston

Governor (three-year term ending in 2025)

Michael K. Givens, FACHE
Administrator/COO
St. Bernards Medical Center
Jonesboro, Ark.

Governor (three-year term ending in 2025)

Michele R. Martz, CPA, FACHE
President
UPMC Western Maryland
Cumberland, Md.

Governor (three-year term ending in 2025)

Dodie T. McElmurray, RN, FACHE
CEO, Community Hospitals
The University of Mississippi Medical Center
Grenada, Miss.

Chair-Elect

Delvecchio S. Finley, FACHE
President/CEO
Atrium Health Navicent
Macon, Ga.

Additional nominations for members of the Nominating Committee may be made from the floor at the annual Council of Regents Meeting.

Additional nominations for the offices of Chair-Elect and Governor may be made in the following manner: Any Fellow may be nominated by written petition of at least 15 members of the Council of Regents. Petitions must be received in the ACHE headquarters office (American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698) at least 60 days prior to the annual meeting of the Council of Regents.

Regents shall be notified in writing of nominations at least 30 days prior to the annual meeting of the Council of Regents.

Thanks to the members of the Nominating Committee for their contributions to this important assignment:

- Heather J. Rohan, FACHE
- Michael J. Fosina, FACHE
- John G. Faubion, FACHE
- Col Stephanie S. Ku, FACHE
- Jayne E. Pope, FACHE
- John M. Snyder, FACHE
- Jhaymee Tynan, FACHE
- Peter J. Wright, FACHE

ACHE Call for Nominations for the 2023 Slate

ACHE's 2022–2023 Nominating Committee is calling for applications for service beginning in 2023. ACHE Fellows are eligible for the Chair-Elect and Governor vacancies and are eligible for the Nominating Committee vacancies within their districts. Those interested in pursuing applications should review the candidate guidelines for the competencies and qualifications required for these important roles. Open positions on the slate include:

- Nominating Committee Member, District 2 (two-year term ending in 2025)

.....
This column is made possible in part by Change Healthcare.



- Nominating Committee Member, District 3 (two-year term ending in 2025)
- Nominating Committee Member, District 6 (two-year term ending in 2025)
- Four Governors (three-year terms ending in 2026)
- Chair-Elect

Please refer to the following district designations for the open positions:

- **District 2:** District of Columbia, Florida, Georgia, Maryland, North Carolina, Puerto Rico & Virgin Islands, South Carolina, Virginia, West Virginia
- **District 3:** Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
- **District 6:** Air Force, Army, Navy, Veterans Affairs

Candidates for Chair-Elect and Governor should submit an application to serve that includes a copy of their resume and up to 10 letters of support. For details, please review the Candidate Guidelines, including guidance from the Board of Governors to the Nominating Committee regarding the personal competencies of Chair-Elect and Governor candidates and the composition of the Board of Governors.

Candidates for the Nominating Committee should only submit a letter of self-nomination and a copy of their resume.

Applications to serve and self-nominations must be submitted electronically to jnolan@ache.org and must be received by July 15. All correspondence should be addressed to Michael J. Fosina, FACHE, chair, Nominating Committee, c/o Julie Nolan, American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698.

The first meeting of ACHE's 2022–2023 Nominating Committee will be held in spring 2022.

Following the July 15 submission deadline, the committee will meet to determine which candidates for Chair-Elect and Governor will be interviewed. All candidates will be notified in writing of the committee's decision by Sept. 30, and candidates for Chair-Elect and Governor will be interviewed in person Oct. 27.

To review the Candidate Guidelines, visit ache.org/CandidateGuidelines. If you have any questions, please contact Julie Nolan at (312) 424-9367 or jnolan@ache.org.

Call for Proposals: Management Innovations Poster Session

ACHE invites authors to submit narratives of their posters for consideration for the 37th annual Management Innovations Poster Session to be held at ACHE's 2022 Congress on Healthcare Leadership. This is a unique opportunity for authors to share the innovative work their organizations are doing with other healthcare leaders. We are interested in innovations addressing issues affecting your organization that might be helpful to others, including improving quality or efficiency, improving patient or physician satisfaction, implementation of EHRs, uses of new technology, and similar topics. Please visit ache.org/CongressPosterSession for the full selection criteria. Narratives should be submitted as an e-mail attachment and sent to PosterSessions@ache.org by Jan. 18.

Registration Open for Diversity Internships Through the AHA Institute's Summer Enrichment Program

ACHE and the American Hospital Association's Institute for Diversity and

In Memoriam

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

Paul M. Angelucci
Shenango Township, Pa.

Robert V. Deen, FACHE
Plano, Texas

Kimberly E. Fierst
Pittsburgh

Richard C. Herrmann, FACHE
Sun City, Ariz.

Andrew J. Norton, MD
Conshohocken, Pa.

ACHE MEMBER UPDATE

Health Equity are pleased to announce that registration is open for the Institute’s 2022 Summer Enrichment Program at ifdhe.aha.org/summer-enrichment-program-overview.

The Summer Enrichment Program grows and strengthens the pipeline of healthcare leaders from underrepresented groups and places diverse graduate students pursuing advanced degrees in healthcare administration or a related field in 10-week, paid internships across the country.

Starting in October 2021, registration opened for host sites and students interested in participating in these experiences. Staff from the Institute will work with participating organizations to match SEP students with host sites in January and again in April. Host site registration is open until May 2, 2022. Internships generally will take place from June through August.

ACHE and the Institute are co-promoting the SEP to increase the number of students who participate in the program each year and, accordingly, increase the number of host sites. Just as students benefit from experiential learning, host sites gain the experience of mentoring, educating and collaborating with new and upcoming leaders. For more information about the SEP or on becoming a host site, visit ifdhe.aha.org/summer-enrichment-program-overview or contact either the Institute at ifd-sep@aha.org or (312) 422-2690 or Anita Halvorsen, FACHE, senior vice president, Executive Engagement, ACHE, at ahalvorsen@ache.org or (312) 424-9370.

PEOPLE

ACHE Chapters Recognized for Their Commitment to Diversity

Five chapters received the 2021 Regent-at-Large Award for their accomplishments in diversity. To be eligible to receive an award, a chapter must actively demonstrate commitment to and successful execution of significant diversity and inclusion initiatives within the chapter, community and the healthcare management field. The following chapters received the award during the annual Chapter Leaders Conference, which took place virtually in October.

- **District 1:** CT Association of Healthcare Executives
- **District 2:** American College of Healthcare Executives of Central Florida
- **District 3:** ACHE of Greater Ohio
- **District 4:** South Texas Chapter of the American College of Healthcare Executives
- **District 5:** Washington State Healthcare Executive Forum

2021 Executive Program: Helping Leaders Advance

In October, nearly 90 healthcare leaders completed ACHE’s Executive Program, composed of Executive, Senior Executive and Physician Executive cohorts. This virtual three-module series was held over five months, with the first module beginning in June and the two subsequent modules held in August and October.

ACHE’s 2021 Executive Program featured sessions led and facilitated by leading healthcare experts, individualized career coaching, professional leadership assessments and other resources that delivered unique insights on topics relevant to the specific challenges that healthcare leaders are facing. The Executive Program supports professional growth and enhances organizational advancement. The participants also benefit from the lasting relationships and shared knowledge that this unique learning experience offers.

The Executive Program will be held in both virtual and in-person formats in 2022. More information will be available soon.

IHF Announces Bowen as President, 2021 Award Winners

ACHE President/CEO Deborah J. Bowen, FACHE, CAE, was appointed president of the International Hospital Federation during its 44th World Hospital Congress in Barcelona, Spain, Nov. 8–11. She was elected IHF president designate in 2019.

Additionally, two member-led organizations received 2021 IHF Awards during the World Hospital Congress. The awards, which include the new American College of Healthcare Executives Award for Leadership and Management, are recognized around the world as the premier awards program to honor hospitals and healthcare organizations. The 2021 ACHE member-led winning organizations are:

Kaiser Permanente Northern California, Oakland, Calif., led by **Carrie Owen Plietz, FACHE**, regional president and ACHE Chair, won the gold Austco Excellence Award for Quality and Patient Safety for its Automated Early Warning System of Adults at Risk for In-Hospital Clinical Deterioration Advance Alert Monitor Program.

This award recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in promoting quality and patient safety.

Spectrum Health, Grand Rapids, Mich., led by **Tina Freese Decker, FACHE**, president/CEO, won the silver Dr. Kwang Tae Kim Grand Hospital Award for its Operational Deployment System & Cascading Communication.

This award recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in more than one service, program or project.

Finally, the new ACHE Excellence Award for Leadership and Management recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in leadership and management.

The 2021 award winners are:

Gold: Dubai Health Authority, United Arab Emirates, for its Rapid Resilience Screening Framework “SPARC.”

Silver: Mutua Terrassa Healthcare Foundation, Spain, for its Integrated Health Care Model in Mutua Terrassa during the COVID-19 pandemic.

Bronze: Emirates Health Services, United Arab Emirates, for its Newborn Screening Program, and NEO Hospital Ltd. (Polish Hospital Federation), Poland, for its establishment of a new hospital together with a Center for Robotic Surgery and new technologies.

This year, IHF received 250 entries from 38 countries and territories, making 2021 the most competitive year for the awards since they were established in 2015.

To learn more about all of the award winners and finalists, visit worldhospital-congress.org/2021-winners/ and worldhospitalcongress.org/2021-finalists/.

Member-Led Organizations Honored for Improving Community Health

Three ACHE member-led organizations were awarded the 2021 AHA Dick Davidson NOVA Award, which recognizes hospital-led collaborative efforts that improve community health.

The 2021 ACHE member-led winning programs and hospital partners are:

Texas Health Resources, Fort Worth, Texas, led by **Barclay E. Berdan, FACHE**, CEO, was recognized for Blue Zones Project Fort

Worth, a community-led well-being improvement initiative that focuses on changing the surrounding environment to make healthy choices easier.

Luminis Health, Annapolis, Md., led by **Victoria W. Bayless**, CEO, was awarded for its COVID-19 Community Prevention Project, which was designed to provide education and resources to the most vulnerable residents in the organization’s service areas.

Memorial Healthcare System, Hollywood, Fla., led by **Aurelio M. Fernandez III, FACHE**, president/CEO, received recognition for Memorial ALLIES (Adults Living Life Independently, Educated and Safe), which addresses social isolation and the related causes that place older adults at risk of losing their independence.

ACHE Life Fellow Installed as NCCCHC Chair



Soltis

Samuel L. Soltis, PhD, LFACHE, was installed as chair of the National Commission on Correctional Health Care Governance Board.

After his election to the board last year, he served as chair-elect during 2021 and will serve as chair in 2022 and immediate past chair in 2023. Soltis joined the board in 2015 as the ACHE liaison to the NCCCHC.

LEADERS IN ACTION

To promote the many benefits of ACHE membership, the following ACHE leaders spoke recently at the following virtual events:

Carrie Owen Plietz, FACHE Chair
2021 Annual Meeting
American College of Healthcare Executives—Rhode Island Chapter
(October 2021)

Annual Business Meeting, Awards Presentation and ACHE Update
Missouri Chapter of the American College of Healthcare Executives
(November 2021)

2021 Annual Meeting and Awards Presentation
Hawaii—Pacific Chapter of ACHE
(December 2021)

Annual Event
ACHE of Western PA
(December 2021)

Anthony A. Armada, FACHE Chair-Elect
Annual Business Meeting & Breakfast
Sooner Healthcare Executives
(November 2021)

ACHE STAFF NEWS

ACHE Staff Members Receive Service Awards

The following ACHE staff members recently received awards for service anniversaries.

10-Year Service Award

Leslie A. Athey, vice president, Strategy & Research, Executive Office.

Belinda Roman, program coordinator, Career Resource Center, Department of Executive Engagement.

Michael E. Cunningham, CAE, vice president, Publications/director, Health Administration Press.

Five-Year Service Award

Julianna Kazragys, FACHE, CAE, credentialing manager, Department of Executive Engagement.

Jennette E. McClain, acquisitions editor, Health Administration Press.

Dawn M. Mathews, manager, Customer Service, Department of Executive Engagement.

Shannon N. Barnet, content marketing specialist, Department of Marketing.

Joe R. Pixler, senior editor, Health Administration Press.

Anita J. Halvorsen, FACHE, senior vice president, Department of Executive Engagement.

ACHE Announces Staff Hire

Following is a new hire announcement.

Ghada M. Morrar welcomed as coordinator, Department of Executive Engagement.



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ACHE Recognition Program SHOW YOUR STARS

The ACHE Recognition Program celebrates members' volunteer service and commitment to their chapter and ACHE. You may have served as a mentor, participated on a committee or served as a chapter leader. There are so many ways to serve and earn points.

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- ★ Service Award = 30 points

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AmericanCollege of
HealthcareExecutives®



Alderfer



Breckenridge



Dilley



Jones



Masterson



Schulte

Jen Alderfer, FACHE, to president, Montana Region and St. Vincent Healthcare, SCL Health, Broomfield, Colo., from president, Good Samaritan Medical Center/transformation officer, SCL Health.

Dianne A. Aroh, RN, FACHE, to senior vice president/CNO, Virginia Mason Franciscan Health, Seattle, from executive vice president/chief clinical and patient care officer, Hackensack (N.J.) University Medical Center.

Allie Breckenridge to COO, Sunrise Children's Hospital, Las Vegas, from vice president, business development and operations, Medical City Dallas Women's Hospital and Medical City Children's Hospital.

David L. Callecod, FACHE, to interim CEO, Ochsner LSU Health System—North Louisiana, from adviser.

Emily N. Dilley to CEO, Kearny County Hospital, Lakin, Kan., from director, marketing and new program development, Prairie Ridge Health, Columbus, Wis.

James Driving Hawk to CEO, Phoenix Indian Medical Center, from director, Indian Health Service Great Plains-area office, Aberdeen, S.D.

Christopher Hall, MD, FACHE, to

chief quality and patient safety officer, PeaceHealth, Vancouver, Wash., from CMO, Providence St. Mary Medical Center, Walla Walla, Wash.

Kevin Gessler Jr., FACHE, to chief administrative officer, Grafton (W.Va.) City Hospital, from financial leader.

Alex Hellinger, DPT, FACHE, to senior vice president/regional executive director, Brooklyn Region, Lenox Health Greenwich Village, Northwell Health, New York, from executive director, Lenox Health Greenwich Village, Northwell Health, New York.

Bernard Jones to vice president, value-based care, public policy and administrative operations, Brigham and Women's Hospital, Boston, from vice president, public policy/chief of staff.

Anthony A. Koffman, FACHE, to regional director, mission, BayCare Health System, Clearwater, Fla., from division administrator, University of Florida, Gainesville, Fla.

David J. Masterson, FACHE, to president, Sentara Obici Hospital, Suffolk, Va., from president, Sentara Williamsburg (Va.) Regional Medical Center.

Tom R. McDougal Jr., Dsc, FACHE, to CEO/managing director,

Manatee Memorial Hospital, Bradenton, Fla., from CEO, Merit Health Biloxi (Miss.).

Pierre Monice, FACHE, to president, MacNeal Hospital, Berwyn, Ill., from senior vice president/chief human resources officer, Midwest HR service area, Trinity Health, Chelsea, Mich.

Alfred E. Pilong Jr., FACHE, to president/CEO, Garnet Health, Middletown, N.Y., from CEO, Novant Health UVA Health System, Warrenton, Va.

Mark Schulte, FACHE, to vice president, operations, Monument Health Rapid City (S.D.) Hospital, from market president, Monument Health Sturgis (S.D.) Hospital.

Laurie Shanderson, PhD, FACHE, to chancellor, Methodist College, Peoria, Ill., from founding dean, School of Health Sciences, Northcentral University, San Diego.

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This column is made possible in part by Cerner.





From ACHE's Chair Officers,
Governors, Regents and Staff



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

Stephen Albanese, DPT, co-CEO, Access Physical Therapy & Wellness, New City, N.Y., received the Clinical-Level Careerist Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Anthony Ashby, FACHE, vice president/COO, CHI Health, Omaha, Neb., received the Outstanding Service 2021 Award from the Regent for Nebraska & Western Iowa.

Navpreet Atwal received the Early Careerist Healthcare Executive Award from the Regent for California—Northern & Central.

Roddex G. Barlow, FACHE, COO, The Hospitals of Providence Memorial Campus, El Paso, Texas, received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Sarah E. Beinkampen, department manager, Cleveland Clinic, received the Outstanding Service Healthcare Executive Award from the Regent for Ohio.

Dylan D. Blackburn, business operations specialist, MultiCare Medical Associates, Tacoma, Wash., received the Early Careerist Healthcare Executive Award from the Regent for Washington.

Toritsesan Boyo, FACHE, senior vice president, hospital operations, John Muir Health, Walnut Creek, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California—Northern & Central.

Sally T. Buck, FACHE, CEO, National Rural Health Resource Center, Duluth, Minn., received the Senior-Level Healthcare Executive Award from the Regent for Minnesota.

Timothy J. Chwirka, associate consultant, Huron Consulting Group, Chicago, received the Exceptional Chapter Leadership Award from the Regent for Iowa.

Caleb J. Colon Rodriguez received the Early Careerist Healthcare Executive Award from the Regent for Puerto Rico.

Carmen Cooper-Oguz, DPT, FACHE, vice president, service line

development/director, rehabilitation, North Sunflower Medical Center, Ruleville, Miss., received the Senior-Level Healthcare Executive Award from the Regent for Mississippi.

Parke A. Corbin, FACHE, director, budget and planning, shared services, UW Medicine, Seattle, received the Senior-Level Healthcare Executive Award from the Regent for Washington. Corbin also received the Chapter Diversity Award.

Marcella L. Doderer, FACHE, president/CEO, Arkansas Children's Inc., Little Rock, Ark., received the Senior-Level Healthcare Executive Award from the Regent for Arkansas.

Paige Dworak, FACHE, president/CEO, East Orange (N.J.) General Hospital, received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Chris Favaloro, finance manager, Memorial Sloan Kettering, New York, received the Early Careerist Healthcare Executive Award from the Regent for New York—Metropolitan New York.

COL Brian T. Freidline, FACHE, deputy commander, Administration, Blanchfield Army Community Hospital, Fort Campbell, Ky., received the Senior-Level Healthcare Executive Award from the Regent for Army.

Alexander S. Gill, FACHE, department administrator, Children's Mercy Hospital, Kansas City, Mo., received the 2021 Missouri Healthcare Executive Award from the Regent for Missouri.

Seona Goerndt, director, patient experience, MetroHealth System,

Want to submit?

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

Cleveland, received the Leadership Healthcare Executive Award from the Regent for Ohio.

Sydney N. Grant received the Early Careerist Healthcare Executive Award from the Regent for Florida—Northern and Western.

Kaye Green, FACHE, CEO, Roosevelt General Hospital, Portales, N.M., received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Paul L. Grossman, CEO/chief experience officer, PLG Experience Solutions LLC, Tampa, Fla., received the Senior-Level Healthcare Executive Award from the Regent for Florida—Northern and Western.

Col Dean H. Hommer, MD, FACHE, CMO, HCA Corpus Christi (Texas), received the Career Achievement Healthcare Executive Award from the Regent for Army.

Domonic M. Hopson, CEO, City of Cincinnati Primary Care, received the Leadership Healthcare Executive Award from the Regent for Ohio.

James C. Houser, administrator, Cleveland Clinic, received the Outstanding Service Healthcare Executive Award from the Regent for Ohio.

Misti M. Hutchison, RN, director, Great Plains Health, North Platte, Neb., received the Early Careerist Healthcare Executive Award from the Regent for Nebraska & Western Iowa.

Grace E. Itiowe, MD, faculty, program coordinator health services management, Brazosport College,

Lake Jackson, Texas, received the Early Careerist Healthcare Executive Award from the Regent for Texas—Southeast.

Embra K. Jackson III, health systems specialist, Veterans Integrated Systems Network 16, received the Early Careerist Healthcare Executive Award from the Regent for Mississippi.

Kiren S. Rizvi Jafry, area operations executive, Sutter Pacific Medical Foundation, Sacramento, Calif., received the Early Careerist Healthcare Executive Award from the Regent for California—Northern & Central.

Charlene Jones, administrative fellow, Brooks Rehabilitation, Jacksonville, Fla., received the Early Careerist Healthcare Executive Award from the Regent for Florida—Northern and Western.

Lisa P. Just, FACHE, patient service area president, Advocate Aurora Health, Downers Grove, Ill., received the Senior-Level Healthcare Executive Award from the Regent for Wisconsin.

Tricia S. Kassab, EdD, RN, FACHE, district vice president, quality/patient safety, Palomar Health, Escondido, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California—Southern.

Johnathan Landor, FACHE, senior director, Children's Mercy Hospital, Kansas City, Mo., received the 2021 Missouri Healthcare Executive Award from the Regent for Missouri.

Clare T. Lee, FACHE, vice president, professional and support

services, Cedars-Sinai, Los Angeles, received the Senior-Level Healthcare Executive Award from the Regent for California—Southern.

Neil A. Mangus, FACHE, director, strategy, Health First, Orlando, Fla., received the Chapter Diversity Award.

George V. Masi, LFACHE, president/CEO, Harris Health System, Houston, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Southeast.

Krista C. Maxey-Kohn, FACHE, service line administrator, The Ohio State James Cancer Hospital, Columbus, Ohio, received the Chapter Diversity Award.

Shannon McDougall, chief safety officer/executive director, enterprise environment of care, occupational health and safety, City of Hope, Duarte, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California—Southern.

Alicia McKoy received the Early Careerist Healthcare Executive Award from the Regent for Ohio.

Brian Michalski, health systems specialist/operations administrator, Clement J. Zablocki VA Medical Center, Milwaukee, received the Early Careerist Healthcare Executive Award from the Regent for Wisconsin.

Ayana J. Miller, FACHE, manager, business operations, Broward Health, Fort Lauderdale, Fla., received the Student Engagement Award from the Regent for Florida—Eastern.

Zachary Miller, CEO, Community Hospital Torrington (Wyo.), received the Early Careerist Healthcare Executive Award from the Regent for Wyoming.

Rudy Molinet, FACHE, CEO, Artemis Synergies Inc., Fort Lauderdale, Fla., received the Student Engagement Award from the Regent for Florida—Eastern.

Kara J. Mulligan, FACHE, associate administrator/director, clinical operations, UW Obstetrics & Gynecology Department, Madison, Wis., received the Mid-Level Healthcare Executive Award from the Regent for Wisconsin.

Andrew S. Mullins, FACHE, CEO, Lifeline of Ohio, Columbus, Ohio, received the Senior-Level Healthcare Executive Award from the Regent for Ohio.

Heidi Murdock, donor relations account manager, LifeNet Health, Plainfield, Ind., received the Regent Award from the Regent for Washington.

Rafael S. Alvarado Noriega, FACHE, CEO, Hospital Metropolitano Dr. Pila, Ponce, Puerto Rico, received the Senior-Level Healthcare Executive Award from the Regent for Puerto Rico.

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

Richard K. Ogden, PharmD, FACHE, assistant director, pharmacy, Children's Mercy Hospital, Kansas City, Mo., received the 2021 Missouri Healthcare Executive Award from the Regent for Missouri.

Shyam B. Paryani, MD, FACHE, CEO, Medical & Dental Consulting, Jacksonville, Fla., received the Early Careerist Healthcare Executive Award from the Regent for Florida—Northern and Western.

Enzo Pistritto, director, program management, Flagler Health+, St. Augustine, Fla., received the LPC Leadership Award from the Regent for Florida—Eastern.

Cory P. Price, FACHE, CEO, West Palm Beach (Fla.) VA Medical Center, received the Leadership Award from the Regent for Florida—Eastern.

Yvonne Renick, RN, Herma Heart Institute clinic manager, Children's Hospital of Wisconsin, Milwaukee, received the Diversity Champion Healthcare Executive Award from the Regent for Wisconsin.

Cesar Rivas, strategy analyst, Children's Hospital Los Angeles, received the Early Careerist Healthcare Executive Award from the Regent for California—Southern.

Robin A. Roling, FACHE, COO, Cheyenne (Wyo.) Regional Medical Center, received the Senior-Level Healthcare Executive Award from the Regent for Wyoming.

Samuel T. Schone, FACHE, market director, orthopedics and neurosciences, MercyOne Central Iowa, Des Moines, Iowa, received the Exceptional Chapter Leadership Award from the Regent for Iowa.

Leonard E. Scott, FACHE, AD, systems of care, Novartis Pharmaceuticals Corporation, East Hanover, N.J., received the Outstanding Service

Healthcare Executive Award from the Regent for Ohio.

Allyssa Stevens, internal management consultant, Mayo Clinic, Rochester, Minn., received the Early Careerist Healthcare Executive Award from the Regent for Minnesota.

Tracey Lewis Taylor, FACHE, COO, Stanford Healthcare/ValleyCare, Pleasanton, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California—Northern & Central.

MAJ Brian F. Turner, FACHE, COO, Kenner Army Health Clinic, Fort Lee, Va., received the Early Careerist Healthcare Executive Award from the Regent for Army.

Vincent Turner Jr., FACHE, assistant vice president, Continuum of Care, St Bernards Healthcare, Jonesboro, Ark., received the Early Careerist Healthcare Executive Award from the Regent for Arkansas.

Cody S. Wales, consumer experience design, AdventHealth, Altamonte Springs, Fla., received the Leadership Award from the Regent for Florida—Eastern.

Mary Anne Weidner, director, quality and compliance, University Health System, San Antonio, received the Chapter Diversity Award.

Maija William, administrative director, Rockefeller University Hospital, New York, received the Volunteer Healthcare Executive Award from the Regent for New York—Metropolitan New York.

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New Initiatives

ACHE chapters explore name change, podcast and more.

Chapters continue to provide value to their members in unique ways. Following are examples of what several have been up to during the past year.

Name Change Provides Focus for ACHE of Eastern Pennsylvania

During the past several months, leaders of the Eastern Pennsylvania Healthcare Executive Network evaluated the chapter’s place within the regional healthcare community. After careful consideration and discussion among board members, leadership changed the chapter’s name to ACHE of Eastern Pennsylvania. The chapter serves 21 counties in eastern and north-eastern Pennsylvania.

Patrick Simonson, FACHE, the chapter’s president, says the American College of Healthcare Executives’ reputation is highly thought of nationally within the field of healthcare administration. From the educational and networking opportunities presented to its members to the prestigious FACHE® designation, ACHE is the professional association of choice for healthcare executives throughout the country, he says.

“As we were looking toward the post-pandemic era of our chapter, we believed it was the perfect time

to rename the organization,” Simonson says. “By transitioning the chapter to ACHE of Eastern Pennsylvania, it will give our chapter a stronger connection to ACHE’s overall brand.”

Following the official name transition in August, the chapter held a virtual event, its annual fall Healthcare Symposium, in October. The symposium provided members with a chance to catch up and earn up to six hours of education credit.

In addition to its name change, the chapter refocused and reenergized its board of directors. This included revising its strategic plan, increasing its members to 15 from nine, and adding chairs of Diversity, Equity and Inclusion, and Early Careerists.

Warming Up to “Coffee With the College” Podcast in Wisconsin

The American College of Healthcare Executives—Wisconsin Chapter recently created a podcast to offer members more opportunities for professional connections and learning.

Called “Coffee With the College,” the podcast offers listeners a conversational venue that makes them feel like they’re having coffee with

colleagues. Through a friendly conversation with a guest who shares stories, experiences and insights, the American College of Healthcare Executives—Wisconsin Chapter hopes listeners will learn more about issues that matter to healthcare leaders and professionals.

The podcast, launched in fall 2020, has offered programs on resilience, professional development success stories, public policy and the impact of big data analytics on healthcare. Visit achewicoffewiththecollege.blubrry.net/ if you would like to listen or subscribe.

The American College of Healthcare Executives—Wisconsin Chapter recently created a podcast to offer members more opportunities for professional connections and learning.

Focusing on Well-Being in Southeast Texas

Since the pandemic started, ACHE—SouthEast Texas Chapter has provided several programs focused on well-being, stress management and combating burnout. For a recent program, the chapter hired Andrew Tarvin, a national humorist, who focused on the importance of humor in our lives. He presented a virtual Humor Happy Hour and spoke about the scientific evidence behind the power of humor in a relaxed atmosphere. Following the hour-long

presentation, during which plenty of laughs were shared, the chapter held an online networking session using breakout rooms. The chapter plans to continue providing opportunities for stress management and well-being for its chapter members in the future.

Diversity, Equity and Inclusion in North Texas

ACHE of North Texas is in the early stages of a deep dive to strengthen its DE&I efforts. At the chapter's annual strategic planning retreat in November, the board facilitated discussions about unconscious biases and the need for the chapter's leaders to espouse and embrace the strong proactive stances in the chapter's new DE&I Statement. This includes the selection of diversity-centric educational topics for events; choosing a more diverse array of speakers and panelists to present at chapter events; and having each committee and the board vet and view everything the chapter does through a lens of ensuring diversity, equity and inclusion.

Although the leadership recognizes there is more they need to do, they hope ACHE of North Texas will be a beacon for other chapters in their efforts to make all individuals in the healthcare community feel included and welcome. ▲

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



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Statement on Diversity

June 2002
November 2005 (revised)
March 2012 (revised)
December 2020 (updated)

As the professional membership society for healthcare leaders, the American College of Healthcare Executives promotes diversity within the healthcare management field, and it believes in the fair and equitable treatment of all people. ACHE recognizes diversity, equity and inclusion as ethical and business imperatives and priorities. ACHE values diversity in its leaders, members and staff, which serves as a catalyst for a stronger workforce, improved decision-making, increased productivity and a competitive advantage. In addition, ACHE fosters an inclusive and equitable culture that recognizes the contributions and supports the advancement of all, regardless of race, ethnicity, national origin, gender, religion, age, marital status, sexual orientation, gender identity or disability. An inclusive environment can enhance the quality of healthcare, improve hospital/community relations and positively affect the health status of society. These priorities are reflected in ACHE's strategies, structure and initiatives.

Within ACHE, the organization promotes diversity in numerous ways, including:

- Diversity-specific accountability for staff. Diversity-specific behaviors are outlined in the Standards of Excellence for staff and incorporated into the performance management tools.
- Inclusive and equitable recruitment and retention practices.
- New employee orientation addressing diversity in the workplace, including recognizing and accepting differences as organizational assets.

- Regularly scheduled education for all staff to help further awareness and understanding of the value diversity, equity and inclusion brings to the organization.
- At-large positions on the Council of Regents to support a diverse and inclusive culture.
- Board and nominating committees that emphasize diversity in slating elected leaders and committee appointments.
- Processes that ensure diversity among our voice-of-the-customer ACHE member committees.

Within the healthcare management field, ACHE promotes diversity in numerous ways, including:

- The Thomas C. Dolan Executive Diversity Program, a leadership development initiative for diverse leaders to support them in their career advancement.
- The Institute for Diversity and Health Equity, co-founded by ACHE, works closely with health services organizations to advance health equity for all and to expand leadership opportunities for ethnic minorities in health management.
- Partnerships with national groups committed to diversity in healthcare management such as the National Association of Health Services Executives, National Association of Latino Healthcare Executives and The Equity Collaborative.
- Online communities for LGBTQ and Asian healthcare leaders and allies.

- Periodic research studies of healthcare leaders in various race/ethnic groups to compare their career attainments such as *Race/Ethnic Comparisons of Career Attainments in Healthcare Management*.
- Periodic research studies of the career attainments of men and women healthcare leaders by gender such as *Comparisons of the Career Attainments of Men and Women Healthcare Executives*.
- The development of resources such as the Executive Diversity Career Navigator, which was created in collaboration with ACHE's diverse partner groups as an online portal to information and inspiration for career advancement.
- Supporting diversity, equity and inclusion initiatives in ACHE chapters through appointing Regents-at-Large, regularly convening chapter diversity leaders and providing diversity-related resources.
- A minority internship, which is a three-month assignment intended to attract racially/ethnically diverse students into the fields of healthcare and professional society management and to further their post-graduate education.
- Albert W. Dent Student Scholarship, which is awarded annually to racially/ethnically diverse students in healthcare management graduate programs.
- Educational programs and publications addressing diversity, equity and inclusion.

Policy Statements

- “Increasing and Sustaining Racial/Ethnic Diversity in Healthcare Management.”
- “Considering the Value of Experienced Healthcare Executives Regardless of Age.”
- “Strengthening Healthcare Employment Opportunities for Persons With Disabilities.”
- “The Healthcare Executive’s Role in Fostering Inclusion of LGBTQ Patients and Employees.”

Approved by the Board of Governors of the American College of Healthcare Executives on March 16, 2012; updated on Dec. 1, 2020.

The Work Anywhere Paradox: How Leaders Can Optimize It

As leaders continue to grapple with fast-changing working expectations and conditions, they will need to continuously reconsider both sides of five paradoxes about ways of working.

Every company is wrestling with the future of work and return-to-office scenarios. Few are settled, as we remain in a prolonged period of uncertainty and vacillation for all leaders whose employees can work remotely.

Many prominent CEOs have declared that they expect workers back in the office; others are saying they will offer flexibility and fully remote or hybrid options for the foreseeable future. There are disconnections between the expectations of executives and workers, between people in different regions and different workplace cultures, and even within individuals themselves.

We strongly believe that the hybrid model is the future of work. But, for leaders, it is also the most challenging of all possibilities to navigate. Getting hybrid right will require pausing and thinking about building on the gains realized rather than trying to recreate a past that is no longer viable. It will require leaders to be agile and thoughtful in addressing five particular aspects of work that have undergone fundamental reassessment: inclusion, communication, career development, productivity and innovation.

Leaders who create new paradigms for how we work can produce thriving cultures with high engagement and performance, a critical advantage in an exploding war for talent. In what follows, only the inclusion paradox is highlighted (for space reasons) along with how it can be optimized.

Inclusion: Personalize vs. Harmonize

The prevailing view is that hybrid work, given that it is partly remote, and inclusivity are at odds, and that an organization's culture will erode in a distributed work environment. People who work remotely may feel excluded from key office-based activities. Those who are newer or less

well-known may not get included in meetings and may feel left out or disconnected from their colleagues.

Such concerns can create or exacerbate disparities in access between the haves and have nots—categories most leaders don't want to have in their organization but that most employees believe exist for various reasons. When some people in a meeting are in person and others are on a video call, the dynamics must be managed very carefully; one best practice is to have everyone get on the video call from their device, even if in the same room, so that everyone appears to be an equal presence.

More generally, leaders with remote workers are far less likely to spot the cues that let them know they need to reach out to someone—cues that are much easier to notice in both formal and informal in-person interactions. This is why it is critical to be proactive and anticipate potential challenges, checking in on remote team members to ensure they feel included, as well as designing meetings and other team events inclusively, with different dial-in locations and device considerations in mind.

Optimize Inclusion

Get to know team members as people, including their aspirations, preferences and needs. On a broader scale, understand various employee personas to appreciate the breadth of needs across the organization.

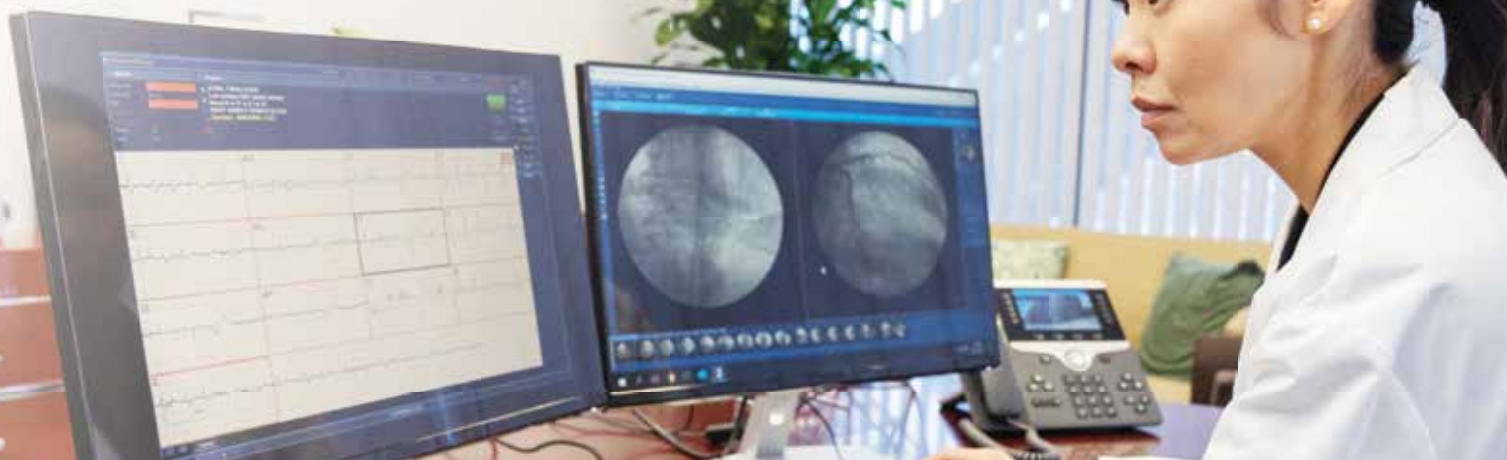
Create flexibility to meet diverse individual and persona-based needs: One size does not fit all, so messaging and engagement must be harmonized into a cohesive strategy while legitimizing personalized options.

Reach out to remote as well as in-person colleagues on a regular basis to stay up-to-date on their needs and challenges. Even the most senior executives can make time to spontaneously check in via video or phone calls, texts, emails, and/or messaging apps—personalized to individual preferences.

Source: Adapted from an article by Yulia Barnakova, digital innovation lead, and Steven Krupp, partner, Heidrick & Struggles, Chicago. To read about each paradox, visit heidrick.com.

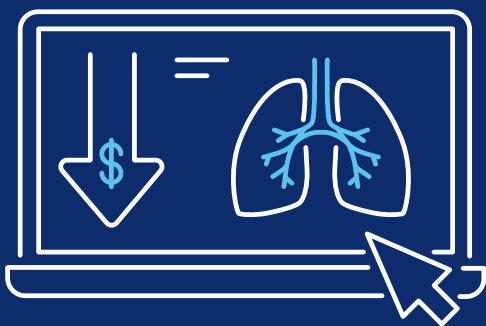
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