

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

JAN/FEB 2024
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Competitive Labor Market

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Improving Food Service

The Payer Point of View

Collaborating
with providers for
healthier patients



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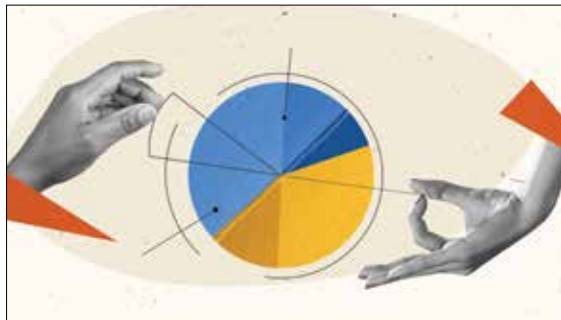


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Deborah L. Rice-Johnson, CEO of Diversified Businesses and chief growth officer, Highmark Inc., and Sean Robbins, executive vice president and chief corporate affairs officer, Blue Cross Blue Shield Association, share their insights.

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Healthcare executives say they've noticed an array of issues impacting everything, from quality of care, to clinician morale, to the financial bottom lines of their organizations, and they're working on numerous fronts to face these challenges.

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Exclusive Content

Read the following articles only at **HealthcareExecutive.org/WebExtras**:

Key Financial Principles for Healthcare CEOs

Charmaine S. Rochester, DHA, FACHE, CPA, in this Q&A says it is essential that healthcare CEOs have a deep understanding of a broad range of topics, from the quality of clinical care to the competitive environment, and how those factors impact financial sustainability.

Improving Onboarding, Transitioning New Team Members

Without adequate onboarding, things can go awry even if a candidate is a great fit. However, leaders can take certain steps to help ease the transition of new hires and not spend a great deal of time doing it.

**Recent Healthcare Executive Podcasts**

You can find the following interviews and more at **HealthcareExecutive.org/Podcast** or search for “Healthcare Executive” in iTunes or your podcasting app of choice:

In “How AI Can Help Transform Hospital Operations,” **Sanjeev Agrawal**, president/COO of LeanTaaS, talks about the risks and challenges of implementing AI.

In “The Future of Patient Care and the Economic Value of Robotic-Assisted Surgery,” **Gary S. Guthart, PhD**, CEO and member of the board of directors of Intuitive, shares the value of robotic technology.

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Randy F. Liss

Strategies for Tough Financial Times

You don't need me to tell you about the precarious financial situations hospitals and health systems are experiencing these days, but a recent report points out a factor pushing organizations into the red: rising reimbursement delays and denials from healthcare payers.

According to data collected by Syntellis Performance Solutions and the American Hospital Association from more than 1,300 hospitals and health systems in the U.S., revenue reductions because of payer claim denials rose 20.2% from early 2022 to mid-2023. Meanwhile, accounts receivable fluctuated monthly as much as \$14,200.

That data is timely given this issue's cover story, "The Payer Point of View" (Page 8). We talked to representatives from two leading health insurers to get their take about such issues as cost, access to care, competition and something sorely needed: more collaboration with providers.

Tighter finances affect everything, and our second feature, "The Financial Impact of a Competitive Labor Market" (Page 16), looks at what providers are doing to make sure their workforce is robust enough to best serve patients. Building feeder pipelines, redeploying staff and investing in innovations that can alleviate burnout are just a few approaches discussed.

Finally, *Healthcare Executive's* new ACHE Members in the News feature highlights Members and Fellows who are making a positive impact on the profession. It's available only online so we can keep the content fresh. Check it out at HealthcareExecutive.org/member-news.

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

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- Women Healthcare Executives Address:
"Navigating a Changing Healthcare Landscape—
Leading With Joy and Authenticity to Improve
Outcomes for All"
- Provider C-Suite Networking Breakfast:
"Be the Best Part of Their Day—Supercharging
Communication With Values-Driven Leadership"
(C-suite Only)
- Thomas C. Dolan Diversity Address:
"Driving Diversity at the Highest Levels of
Healthcare Leadership"



Leadership Insights Sessions

Take the opportunity to explore big ideas with forward-thinking healthcare leaders. Here are just some of the sessions to be held:

- Health Equity
- Quality and Patient Experience
- Workplace Violence
- ChatGPT and Generative AI
- Healthcare Inequities
- Financial Stability



Solutions Center

The Solutions Center is the place to be for networking and relaxation at Congress. Visit the ACHE Membership Booth to learn about the FACHE® credential or ask questions about your recertification; stop by the Health Administration Press bookstore to purchase books at 50% discount; and drop in for an executive portrait.





Deborah J. Bowen,
FACHE, CAE

Recommitting to our Mission

Key deliverables to advance you and the field.

With a new year comes new opportunity to recommit to our mission: advancing our members and health-care leadership excellence. ACHE takes great pride in delivering on that mission and executing on our Strategic Plan, which supports our ambitions to do our best in service to our members, our profession and our field. In that spirit, we are reminded of our professional commitment to lead for safety and equity so that everyone receives the care they need and deserve. In 2024 ACHE's Board of Governors will look more deeply into our Strategic Plan to further expand our commitment to our vision, mission and values. During the year, we will ask you to identify your highest goals for our profession.

The Board prioritized key deliverables in the current plan that will come to fruition this year. These strategic priorities are designed to advance the intent of our work, leveraging our roles as Catalyst, Connector and Trusted Partner. Perhaps most importantly, they provide evidence for how we can advance our members and the field.

As a Catalyst, over the past year the Board articulated a specific priority to make leading through a lens of equity an essential leadership skill. Through a Delphi approach interview process

with industry experts, CEOs and many others, ACHE identified the specific competencies that drive an inclusive culture. Soon we will be releasing what we uncovered, and the work will be available as a DEI Competency Assessment Tool.

The competencies are aligned with the challenges and opportunities leaders are experiencing today and will be updated annually. Members can use it to assess their skills in leading for equity, identify areas of strength and note those that may need attention. The tool can also be used in many other ways such as team development. This work will supplement our resources to help leaders drive efforts on quality as well as develop themselves. Ultimately, we hope to provide the pathway to help leaders create environments where everyone can thrive.

As a Connector, chapters remain a Board-level priority. As the Board finalized the new FACHE® CEU requirement that took effect Jan. 1, 2024, special attention was given to adding more options for chapters to extend their reach and impact. As a result, chapters can now offer up to 24 hours of education that qualifies for ACHE credit applicable toward Fellow status—in person and virtually. Equally important is that we have

upgraded the education resources chapter leaders have available to ensure the options are up to date and use the best relevant resource references, PowerPoints and formats that optimize learning. With nearly 160 options now in the inventory, members have plenty of opportunities, nationally and locally, in person and virtually, to learn and grow.

Finally, as a Trusted Partner, we remain committed to you. The Board and staff remain vigilant in providing best-in-class education and networking. Last year, we had record-breaking attendance at Congress, and we are proud of the lineup we have planned this year. Our featured speakers are focused not only on big ideas to address the myriad of complex issues we face in healthcare but also on how leaders can build and inspire teams toward success and advance the health of patients.

Beyond Congress, we want to make sure we provide top-notch education throughout the year and other resources when and where you need them. That's why the Board has accelerated our efforts to create unparalleled digital experiences for you, including a new website expected to debut by the end of the year. We look forward to telling you more about our digital evolution as we progress.

As you take inventory of what you have achieved and what you hope to become this year, know that we are there beside you and support you regardless of your role, title or position. As we enter our new strategic planning cycle this year, we will want to hear from you. Every member will

(Cont. on Page 35)

big ideas.

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Welcome & Opening Session: Parker B. Francis Distinguished Lecture: Leadership, Culture and the New Principles of Influence

Daniel H. Pink, *New York Times* Bestselling Author

Drawing on a rich trove of social science and cutting-edge practices from organizations around the world, Daniel H. Pink will demonstrate the new ways leaders are persuading, influencing and motivating others. He will show the power of underused techniques, such as perspective-taking, problem-finding and using purpose as a motivator, and offer concrete steps to put these ideas into action.



Arthur C. Bachmeyer Memorial Address: Intentional Leadership: Tools for Maximizing Your Success

Carla Harris, Senior Client Advisor, Morgan Stanley

Join Carla Harris as she discusses the importance and the power of perceptions in the workplace, the key relationships that you must have to ensure your success, and the power of authenticity and its place in influential leadership. Attendees will walk away with critical guidance on the essential components of being a powerful and intentional leader.



Malcolm T. MacEachern Memorial Address: Creativity for Breakfast—Innovation in a Tumultuous World

Mick Ebeling, Founder/CEO, Not Impossible Labs, Producer/Filmmaker

With examples from Not Impossible's newest world-changing solutions, Mick Ebeling will share insights into the way of the "hacker-maker" and the gift of positive failure. He will empower leaders' resourcefulness and remind them that the healthcare landscape has never been more primed for breakthrough innovations, quite possibly with the help of some zip ties and duct tape.



Leon I. Gintzig Commemorative Address: The Caring in Healthcare: Challenges and Opportunities in a Technological Era

Abraham Verghese, MD, MACP, Professor/Vice Chair, Theory and Practice of Medicine, Stanford University School of Medicine/Bestselling Author

Artificial intelligence could liberate providers from their clerical and documentation burden and allow for more meaningful patient interactions. It might also ease the epidemic of provider burnout. However, without forethought, oversight and user input, every new advance can have unintended human consequences. In this session, Verghese will focus on how healthcare systems need fiscal soundness and inspired leadership that deliver caring to people with presence and empathy.



The Payer Point of View

Collaborating with providers
for healthier patients

Payers are a crucial component in helping shape the healthcare landscape on issues of cost, access to care and competition. Though *Healthcare Executive* is dedicated to providing content geared toward healthcare professionals in the provider space, they and payers are working closer than ever before. Two leading payers share their insights on several key areas valuable to ACHE members.



Deborah L. Rice-Johnson

**CEO of Diversified Businesses and
chief growth officer, Highmark Inc.**

Highmark covers the insurance needs of approximately 7 million members in Pennsylvania, Delaware, New York and West Virginia.



Sean Robbins

**Executive vice president and chief corporate affairs
officer, Blue Cross Blue Shield Association**

The Blue Cross Blue Shield Association is a national association of independent, community-based and locally operated Blue Cross Blue Shield companies.



The Payer Point of View

HE: The tension between health insurers and providers appears to have peaked recently. Do you think that's the case, and if so, is it necessary to control costs?

Rice-Johnson: The last few years have transformed the world and the health industry alike. I think we are all still adapting to the shock of the pandemic and its long-lasting impact on healthcare.

Many hospitals and health systems across the country are facing challenges in today's economic climate, from rising labor costs to supply chain issues to recovering from the pandemic. Where, when and how care is delivered is also changing.

We recognize these challenges and have negotiated what we believe are fair and reasonable reimbursement changes with our valued provider partners. We have a responsibility to our members to negotiate terms that do not place an undue financial burden on them and jeopardize access to affordable care. Our goal is to work with providers to balance access to high-quality, affordable care for our members with fair and reasonable payments to providers.

Robbins: Health insurers and providers are all working toward a shared goal—to provide high-quality, affordable healthcare. There's no question that both are dealing with unique challenges coming out of the pandemic years, but our biggest focus is on our members. The ever-rising cost for delivering care is simply unsustainable. Only when working together can we navigate the many challenges and opportunities that exist in today's landscape. But, as an industry, we must do things differently than in the past.

HE: Is the recent uptick in claims denials playing a role in how payers and providers can collaborate more closely? How?

Rice-Johnson: When it comes to claims reviews, our goal is to determine appropriate and fair reimbursement for services and to determine the appropriate procedure code for the services provided. That ensures that the cost of care for our members is fair and accurate, that members are not exposed to unnecessary out-of-pocket costs, and that the overall cost of care remains affordable.

I think, broadly speaking, insurers and providers are negotiating and operating in good faith. Philosophically, we're aligned on quality care and outcomes. And, as more care is delivered under value-based arrangements, financial incentives of payers and providers are aligned. When you incentivize high-quality care and health outcomes, rather than number of services delivered, everyone wins. Providers are rewarded for delivering the best-quality care. Members and patients are healthier and have lower costs through better health management.

HE: What do you say to hospital system CEOs thinking of sponsoring their own health plan to have some leverage in contracting with other payers?

Robbins: We welcome competition. Many of our plans compete with provider-sponsored health plans and have for many years. We have seen many enter the health insurance space with the idea that it is simple to operate a plan, only to leave the market a few years later—which hurts consumers counting on that insurance the most.

Consumers are best served when they have more choices that fit their needs from stable and trusted

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The Payer Point of View

insurers, which drives down prices and makes health-care more affordable. Healthcare is not one-size-fits-all, and because local Blue Cross Blue Shield companies are in every ZIP code in the country, we can tailor our health plans to meet local needs of every community.

One essential ingredient in building relationships between payers and providers is trust. We see this work in our Total Care Program, which includes more than 156,000 providers. The program recognizes doctors who focus on healthcare instead of sick care, and it's based on a shared goal of keeping people healthy and costs down. Whether value-based care arrangements or high-performing networks, Blue Cross and Blue Shield companies are constantly working to collaborate most effectively with providers to serve members.

Rice-Johnson: I can speak to our own experience at Highmark. During my career, Highmark has transformed from a traditional Blue Cross Blue Shield insurer into what we call a national blended health organization—one that brings together a diverse portfolio of businesses that cover a spectrum of essential health-related needs in service to our customers and communities, including health insurance, healthcare delivery, population health management, dental solutions, reinsurance solutions and innovative technology solutions.

As a blended health organization, we're able to eliminate the fragmentation that sometimes plagues the health industry. As both a payer and provider, we are able to innovate in partnership with our Allegheny Health Network clinicians to deliver better health outcomes and a better experience for our members and patients.

I would also encourage health system leaders to think of partnerships in a broader, more holistic sense. We partner with providers throughout our markets in Pennsylvania, Delaware, West Virginia and New York in a variety of ways. It's not just about owning or acquiring particular assets. It's more about finding like-minded, forward-thinking groups and working with them to elevate both the patient and clinician experience.

For example, we have partnered with Penn State Health to create a world-class, community-based network of care in central Pennsylvania. That partnership has expanded critical health access points, improved health equity with culturally competent and bilingual mobile healthcare and education initiatives, and lowered costs for local employers through an insurance product that incentivizes receiving care from Penn State Health and select independent providers.

HE: The price transparency rule for health insurers took effect last year. Has it changed how you operate?

Rice-Johnson: We are supportive of members and patients understanding their bills, their benefits and the cost of their care. The challenge is to ensure that they're getting the right pricing information—meaning that they know what their actual out-of-pocket costs will be, given their insurance coverage. That kind of pricing information is actionable and useful.

At Highmark, we have price transparency tools that provide members with the information they need to make smart decisions about their healthcare and healthcare spending. By providing quality and cost comparisons along with other practical information, members are offered an integrated suite of tools. This makes cost and quality not only transparent but

meaningful. It helps members across all plan types make educated choices when deciding on medical care.

Robbins: Even before the rule was established, BCBS companies were providing members with easy-to-use tools to estimate the range of costs for specific procedures from providers in their communities. We remain committed to making the entire healthcare industry more transparent—closely working with federal agencies to meet the Transparency in Coverage rule deadlines and make additional resources readily available to the public.

That being said, machine-readable files are not consumer friendly. In fact, they are extremely complex and not likely to be of much use to members who want to understand their personal costs for healthcare services.

That's why we're focusing on tools that help people easily access and compare information about out-of-pocket costs and doctors' ratings and reviews and confirm if their preferred healthcare provider is in-network.

HE: Medicare Advantage is being heavily scrutinized by the Centers for Medicare & Medicaid Services, which promises changes. Is Medicare Advantage the future for the majority of seniors, or will enrollment level off at about 60%, which is where it is today? Are you optimistic, pessimistic or unsure at this point?

Robbins: Medicare Advantage has a proven track record of reducing costs and improving care. Studies show those plans outperform original Medicare on quality measures, including reduced hospital admissions, fewer days in the hospital and fewer emergency room visits.

We believe Medicare Advantage will continue to grow because of the value it brings to members. MA works best when it is member-centered, and care is provided in partnership with providers with a focus on care coordination and management to support preventive and chronic care of our members. We will continue to enhance our capabilities to ensure our Medicare members get the right care, at the right time, in the right setting, and we do that by leveraging data to support clinical decision-making and local investments.

Rice-Johnson: I would say we are optimistic about Medicare Advantage and are investing every year in making our plans better for our members.

Plus, there are lots of exciting things happening in Medicare Advantage. CMS has allowed plans to explore innovative benefits like over-the-counter allowances and Part B givebacks that provide a great deal of value to a lot of MA beneficiaries. The flexibility to go beyond traditional Medicare has become a hallmark of the MA program.

But, at the end of the day, the primary role of your health insurance is to keep you healthy and make sure quality care is affordable and accessible.

The plans that are doing well are doing the basics right—they're ensuring affordable access to high-quality care and providing their beneficiaries with the best in customer service.

Successful MA plans provide access to doctors and hospitals, both local and nationwide, and a focus on the benefits that matter most to members—robust and affordable medical and pharmacy coverage along with traditional supplemental benefits like dental, vision and hearing. These supplemental benefits aren't available in traditional Medicare and allow for Medicare Advantage plans to care for the whole person.



The Payer Point of View

It's clear that older adults see significant value in MA plans. More than half of eligible seniors now choose to enroll in Medicare Advantage, and more than 90% of those enrolled in MA are satisfied with their plan—higher than the satisfaction rate for traditional Medicare.

HE: What is your value-based care strategy? Has it been a success?

Rice-Johnson: We are investing in value-based care to evolve from a fee-for-service model to one in which keeping people healthy and having positive outcomes benefits patients, providers and payers alike.

Our value-based care programs incentivize physicians to work with us toward common care and cost goals. Physicians receive higher reimbursements when those care and cost goals are met and when our members have better outcomes by taking their medications, getting recommended screenings and better managing chronic diseases.

Highmark also works to ensure that physicians have the information they need to meet these goals, including insightful tools, custom reporting and personalized field-based support dedicated to value-based programs.

Since our True Performance VBC program started in 2017, participating primary care physicians have helped to potentially avoid \$3 billion in healthcare costs due to lower rates of emergency care and hospital stays.

Data shows that members who receive care from providers in our value-based programs are significantly

more likely to complete annual wellness visits, receive recommended cancer screenings and complete recommended diabetes care compared to those in non-value-based programs.

Value-based care is a critical component of aligning incentives among healthcare stakeholders and addressing the rising cost of care in the U.S. We need to reward providers for doing what they do best: caring for patients and helping them improve and manage their health. Getting to a holistic, value-based system of care is a process that is decades in the making. We're not there yet, but we're happy with the progress we're making.

Robbins: BCBS companies are seeing success across our value-based care programs, with better control of chronic conditions, more delivery of preventive care and less utilization of unnecessary services. Through value-based programs, our data shows patients are healthier—with 7% more appropriate antibiotic use, 12% better adolescent wellness care and 13% lower utilization of emergency services for non-emergency needs.

These programs are a true shared risk between insurers and providers—with each of us being equally accountable for patient outcomes, safety and lower costs. Our members rely on us to continue to prioritize value-based care delivery and remove waste from outdated fee-for-service models.

To continue to advance this work, we need to focus beyond primary care. We can only achieve value-based outcomes if specialty care works with the incentives in the primary care value-based care model.

We also need to enhance our measurements to make sure value-based incentives are tied to healthcare delivery that meaningfully improves patients' outcomes, so they can lead healthier lives.



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Surgical site infections (SSI) pose a challenge across healthcare systems. Expanding the use of da Vinci surgery can help drive down SSI rates, avoid CMS penalties, and regrow case volume.

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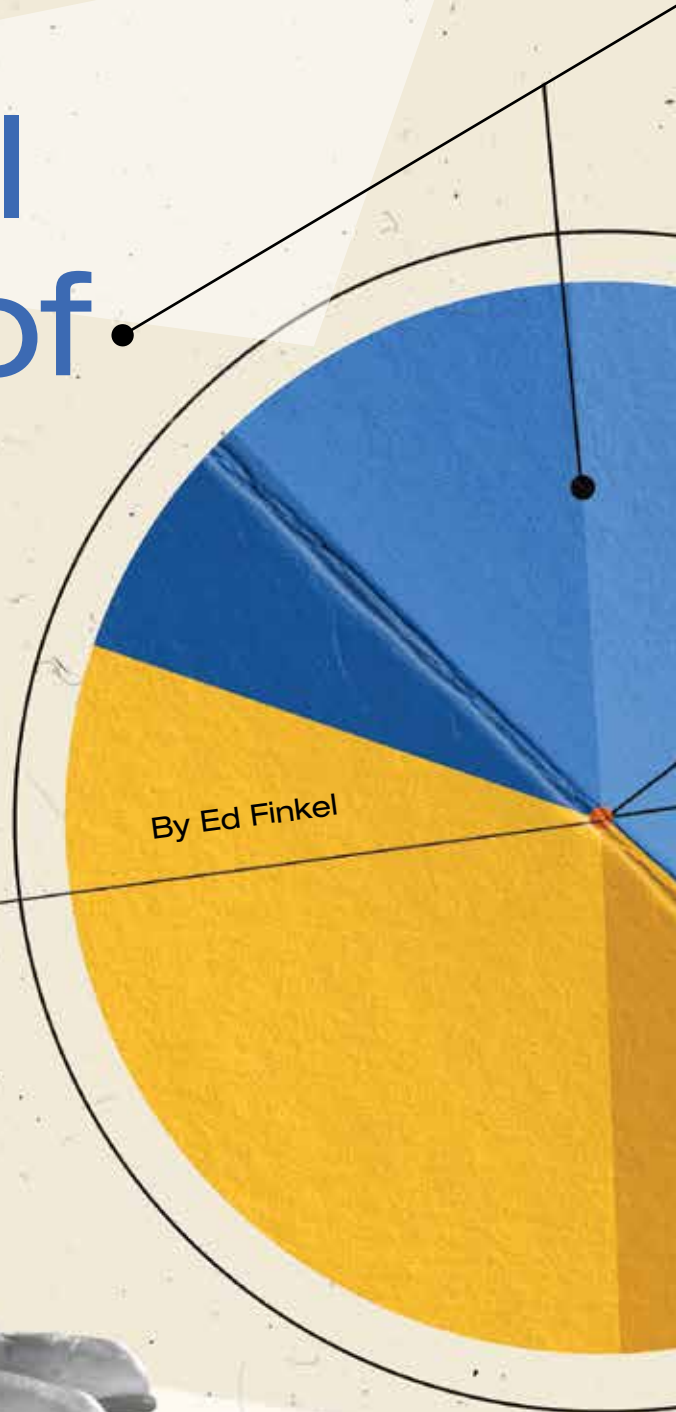
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The Financial Impact of



By Ed Finkel

a Competitive Labor Market

A hand is pointing towards a pie chart. The pie chart has a large blue segment and a smaller orange segment. A line connects the hand to the orange segment. Another line connects the hand to the blue segment. A third line connects the hand to a black dot on the blue segment.

Healthcare executives and industry analysts say the tight labor pool is impacting everything from quality of care to clinician morale, to the financial bottom lines of their organizations, and they're working on numerous fronts to face these challenges. Those include workforce friendly shifts like refocused hiring and provider deployment, process improvements, more flexible scheduling and even in-house agencies for those who prefer being contractors, along with technological solutions ranging from AI to telehealth.

The Challenges Facing Healthcare

Lori Kalic, a Cleveland-based audit partner and healthcare senior industry analyst at RSM, sees a few major challenges related to labor and finances in the healthcare sector, as operating margins remain below where they were pre-pandemic. Many systems are at or near zero, and most of the rest are at no more than 3%.

"The federal relief funds are gone, there's all this inflationary pressure and liquidity is a problem," says Kalic. "Expenses are increasing at a higher rate than reimbursements."

The Financial Impact of a Competitive Labor Market

Kalic goes on to say that many healthcare organizations across the country are streamlining their operations to improve their operating margins, which includes addressing their labor strategy.

“Health systems need to think about delivering healthcare in a different way,” she says. “A lot of systems are cutting ancillary support and overhead roles. They’re reviewing their shared service models to ensure they’re supporting services efficiently.”

Demand for labor will continue to exist, Kalic predicts, noting that

the sector added 450,000 jobs between 2020 and 2022, according to the Bureau of Labor Statistics. “I’m seeing the utilization of traveling nurses trending downward, but I do believe that hospitals are still paying a significant amount of dollars for labor,” she says.

The labor picture varies somewhat from market to market, but there are commonalities, says Therese Fitzpatrick, RN, senior vice president at Kaufman Hall, who leads the Chicago-based consultancy’s healthcare workforce efforts. “The data from California looks a little bit different than it might in a

suburban area of the Midwest,” she says. “We have seen significant increases in salaries and flexible benefits and some very creative benefit strategies that started during the pandemic but have continued. These include flexible benefits that are meaningful to the various age spectrums of employees in nursing and other areas.”

All healthcare institutions are facing higher costs for labor, supplies and building materials, says Roxie Wells, MD, senior vice president, chief physician executive and strategy officer for the coastal region at Novant Health in Wilmington, N.C., who is also an ACHE Member. She cites labor statistics that predict an average of 195,000 annual openings for registered nurses through 2030.

“This doesn’t include allied health jobs,” she says. “There is a significant need for an increase in the nursing and allied health workforce. [The current shortage] adversely affects the delivery of healthcare, which makes it important for us to innovate and think about how we can deliver care differently.”

In Mississippi and Louisiana, the Franciscan Missionaries of Our Lady Health System has experienced the same challenges as others, says Kristin Wolkart, RN, FACHE, NEA-BC, CNO, who

“There is a significant need for an increase in the nursing and allied health workforce. [The current shortage] adversely affects the delivery of healthcare, which makes it important for us to innovate and think about how we can deliver care differently.”

—Roxie Wells, MD
Novant Health



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recently spent six months as interim president for the Jackson, Miss., market.

“We have shortages in staffing, with a huge focus on nursing,” but also encompassing radiology, the respiratory lab and other caregivers, she says. “Our world has changed since the early part of 2020. None of us were prepared to have the exodus of people who retired or went on to take lucrative travel contracts. ... The majority of [ideas] we’re working on are applicable to any department having shortages. Often, we’re using the nursing department as an incubator” for the rest of the health system.

Turnover at Franciscan Missionaries peaked between 25% and 28% between mid-2021 and early 2022 as the repeated waves of COVID-19 led to burnout, Wolkart recalls. “We would think, ‘it’s over,’

everybody would take a breath, and then the next wave would come,” she says. “People were leaving because a colleague left and took a big contract. They were recruiting their friends. It became very hard with the lockdowns and work-at-home options.”

In southern California, Loma Linda University Health Hospitals experienced the same spike of temporary labor a couple of years ago. The tightness of the labor market has eased somewhat, says CEO Trevor Wright, FACHE, “but it’s still a super-competitive labor market. Nursing and clinical lab scientists are probably the two that immediately spring to mind. Physician recruitment has seen some of the same challenges. There’s been significant wage escalation because of the inflationary environment. ... And post-COVID, a lot of people have rethought almost everything

about life. It accelerated retirements of people who were relatively close to retiring.”

Healthcare institutions have faced shortages of people and continue to struggle with outdated technology, Wright says. “We’re one of the few places that still use fax machines,” he says. “We haven’t really leveraged technology because we haven’t had to, frankly. ... Disruption, we’ve been ripe for it. I think it’s going to be a good thing, both for taking expenses out of the equation and [boosting] customer satisfaction. It’s going to be bumpy and difficult, but I think we’re going to get to a better space. It’s taken this industry longer than a lot of others.”

Hiring and Retention

To help ease the shortages in nursing and other fields, Kalic sees the need for health systems to begin hiring people earlier in their career trajectories, perhaps by partnering with educational institutions to increase the accessibility of clinical programs to prospective students. (For more about this topic, read this issue’s Careers column on Page 36.)

“How do colleges and universities attract and retain more students in nursing programs?” she says. “It’s going to be critical to recruit teachers. We all need healthcare: There will be approximately 76.4 million baby boomers fully eligible for Medicare by 2030. We’ve got to

“It’s still a super-competitive labor market. Nursing and clinical lab scientists are probably the two that immediately spring to mind.”

—Trevor Wright, FACHE
Loma Linda University Health Hospitals

find a way to serve this population.”

Fitzpatrick also counsels providers to build a solid feeder pipeline that’s both “outside-in and inside-up,” she says. “You need to make sure you have a pipeline of candidates into your organization. In addition, once those candidates are in your organization, you need to focus a great deal of attention on employee development. For example, what additional education—through creative partnerships with local community colleges or technical schools—do you need to be able to create that next step for employees?”

Novant Health starts early in the process, providing younger people a look at the nursing field and other clinical options, says Wells, a former member of the American Hospital Association Board of Trustees and current member of AHA’s Task Force on Workforce. “Even in high school, we talk about the nursing field, the merits of becoming a nurse and what that means to individuals,” she says. And then “work closely with colleges, including community colleges, to boost their ability to increase the number of nursing slots they have.”

Novant Health holds specific hiring events, totaling 83 both on-site and virtually for nursing recruitment alone in the first six months of 2023, Wells says. “They’re not just held at our hospitals—we’ve taken

The Anatomy of an In-House Contract Agency

Franciscan Missionaries worked with a vendor to implement software that, at first, helped to manage and standardize vendor contracts, which went live in the late spring. Then in September, the system opened an in-house agency to provide current and former employees options like they would have from external contractors, based on three salary tiers: the lowest for those who only want to work in one market, mid-tier for those willing to travel to two places within the same state, and the third willing to go “wherever you need me,” Wolkart says. “Our goal is to hire 100 nurses within 100 days.”

The conversion started with nurses and quickly moved on to respiratory therapy, radiology and “other key, high-shortage, high-demand professional services,” she says. The system is also migrating the 300 to 400 nurses in the previous in-house contract model to the new agency. “It’s about having one source of truth, clarity and transparency,” she says. “How do we best manage our resources and compete with external contract labor?”

Franciscan Missionaries expects to see the reliance on high-priced agency personnel to continue dropping, Wolkart says. “That’s been a huge blessing,” she says. “The workforce has told us the old way of doing 12-hour shifts—you work full-time, you get full benefits and this is what you do—not everybody wants to work that way. We’re adding work-on-weekend options. We’re adding 7-[days]-on, 7-off. We’re creating different opportunities to meet people where they are.” And nursing turnover has fallen below 15% in most markets, meeting or exceeding national benchmarks.

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them to college campuses, community gathering locations and online to expand our reach outside of the region,” she says. “Talent acquisition and hiring leaders often partner at these events to make sure we provide qualified applicants an offer, or at least interviews, on the spot.”

From a retention standpoint, Novant Health leans into its emeritus nurse program, comprised of experienced nurses who serve as coaches and mentors, Wells says. “They’re able to nurture the newer nurses who are joining the workforce, which adds to their comfort level when caring for patients,” she says. The system also has a nursing residency program, in which nearly

120 nurses have participated over the past year in the coastal region. “It helps them get acclimated to being a new nurse and gives them the opportunity to work on various floors and determine what their best fit is—what part of nursing they enjoy most,” she says.

Redeployment and Flexible Scheduling

To boost employee satisfaction while also finding cost-related efficiencies, systems are redeploying their nursing and other staff where they’re most needed, with help from granular data. They’re also becoming more flexible in scheduling in the wake of the contract nursing boom, when clinicians gained wider

options. Some providers are even starting their own in-house agencies to hire clinicians as contractors, if that’s what they prefer.

Kalic sees health systems using data to more efficiently deploy personnel. For example, a system turning people away from its emergency department examined trends in terms of when the ED was experiencing higher volumes—and redeployed its clinical teams in anticipation. “Health systems need to be looking at patient acuity,” she says. “They need to be thinking about, ‘We’ve got this amount of clinical capability here. Where is the acuity trending, and where is it going to go?’ And then make sure you’ve got people to deal with it.”

“How do you empower middle managers and get the voice of the customers—the boots on the ground—to create improvements? Who knows better what needs to be fixed than the folks who do the work day-in and day-out?”

—Kristin Wolkart, RN, FACHE,
NEA-BC
Franciscan Missionaries of Our
Lady Health System

Kalic also believes systems likely will need to redeploy more caregivers into the home health setting, based on a Bureau of Labor Statistics prediction that the employment of home health-care and personal aides will grow 25% from 2021 to 2031—adding a total of 712,000 job openings. “Healthcare consumers are demanding that care be accessible,” she says. “I believe home health is going to be a popular option for many.”

Kaufman Hall has been focusing on optimization of the clinical workforce as well, based on mathematical techniques and logistics science used in other industries to closely align staff with patient demand, Fitzpatrick says. This has facilitated patient

movement from the ED to the OR and elsewhere in the facility.

“We’re helping organizations ensure they have the right caregiver, at the right time, with the right skill set for a particular patient group,” she says. “We’re doing a lot of work around predictive modeling, studying the demand and helping to shape that demand. ... We’re getting away from the old way of looking at averages, and basing budgets and staffing patterns on the average day’s census at midnight. We’re now able to use much more granular information.”

In a similar vein, Loma Linda University Health Hospitals has been working to ensure clinicians are practicing at the top of their licenses and scopes of responsibility, which both inspires them and brings efficiencies to the organization, Wright says. “I can look across the organization and see where we have, for example, nurses doing things that don’t really require a nurse,” he says, like an RN handling a clinic nurse role that could be accomplished by an LVN, or an LVN doing a patient vitals and rooming role that a medical assistant would be able to do. “It’s been a rebalancing to make sure we have the right level of support and the right level of clinical professionals doing the right work. ... The overall net effect of that should be to lessen the salary burden. Efficiency is something we’ve always prided ourselves on.”

Another type of redeployment involves giving clinicians and other staff more flexibility in terms of scheduling or benefits—or how their hiring arrangement works—for those who want to work fewer hours, or outside the traditional 12-hour shift for personnel such as nurses. “We’re seeing different combinations of typical shift lengths to meet employee needs,” Fitzpatrick says. “For early careerists, we’re seeing some interesting benefits around childcare subsidies and so forth [including housing and commuting subsidies, as well as educational loan forgiveness and investment] that perhaps hadn’t been as prominent prior to the pandemic.”

Though contract labor certainly still has a presence, the numbers have trended down a bit partly due to such benefits attracting staff back to organizations, Fitzpatrick says. “But hospitals are also coming up with some interesting alternatives, with float pools and flexible private-label staffing companies within larger systems,” she says. “They’re approximating some of the benefits that ... attracted [nurses and other caregivers] to travel contracts. Organizations are beginning to build those sorts of things within their systems.”

Franciscan Missionaries of Our Lady Health System, for instance, would love for everyone to take a full-time staff job. While some still do, the organization recognizes that “the

world has changed,” Wolkart says. “We’ve had to change with it.” The system started with external contract labor in 2020, but “those rates became unbearable, particularly for nursing but also for the respiratory lab, radiology and other bedside caregivers,” she says. So the system moved to in-house contracts, “still at a much higher rate, but cheaper than the external agencies.” For fiscal year 2023, which ended June 30, external contract labor expense was down \$30 million, she adds.

Franciscan Missionaries also launched a Leadership Development and Accountability Program in 2020 that empowers middle managers to be “CEO of their work area” in every sector of the organization, Wolkart says. On a rotating basis, departments have “100-day workouts” during which the leader’s goal is to bring about eight significant improvements. “Sometimes it’s financial—how do we reduce waste or grow programs,” she says. “Sometimes, it’s how do we improve the patient experience?”

The organization has undertaken six or seven rounds of those over the past three years, with occasional breaks during the peaks of COVID waves, “when people were too exhausted to do another project,” Wolkart says. “How do you empower middle managers and get the voice of the customers—the boots on the ground—to create improvements? Who knows

The Financial Impact of a Competitive Labor Market

better what needs to be fixed than the folks who do the work day-in and day-out?”

For example, a radiology leader at St. Dominic's Hospital in Jackson, Miss., realized the scheduling tool in the EHR was built in a way that led to an enormous backlog for patients trying to schedule MRIs, some of whom were opting to go elsewhere. “They had too much time slotted for certain tests,” Wolkart explains. “One test took 20 minutes, but it was built in the [EHR] to take an hour. They were able to clean that up and get the actual times in—and add more slots.”

Technological Innovations

Health systems are drawing upon technology to bring about these and other innovations. The burgeoning use of artificial intelligence is a key part of that, Kalic says. “Technology is being utilized to alleviate burnout,” she says. “Mundane and repetitive tasks are being identified, and leaders are figuring out how can they use technology to handle those tasks, rather than people? ChatGPT is one tool that's being used to read patient messages and draft responses.” Transcription, scheduling and handling of insurance claims and the prior authorization process are other use-cases of AI, she adds.

While clinicians still need to review and approve AI-generated patient responses, reducing the clinical documentation they need to churn

out after being with patients all day will represent a “transformative” change, Kalic adds. “We're just on the edge of this,” she says.

“Organizations are going to have to find the capital to invest in it. It's not cheap. But to fix the operational deficits, providers are going to have to spend some dollars to get the technology embedded.”

Telehealth is another technological opportunity, Kalic says, if insurers can be convinced to provide adequate reimbursement now that the pandemic is past. “For many people who can't access healthcare, telehealth is a great option. I'm hopeful this will continue to be a solution,” she says. “It's a challenge. Reimbursement rate increases have not kept pace with expenses. That is not a sustainable model.”

Fitzpatrick of Kaufman Hall is working with a couple of organizations that have embraced the virtual nurse concept at a time when experienced nurses are wanting to cycle off day-to-day patient care and a large swath [of new nurses] are entering the field. “How do we best leverage those experienced folks? That is our brain trust, if you will,” she says. “An experienced nurse can sit in a command center and provide support for nursing staff on a unit, through direct communication on a device that the [bedside] nurse might wear. ... This is an opportunity to connect with an experienced nurse and get tips and last-minute coaching.”

Wright of Loma Linda University Health Hospitals also sees AI and machine learning as a way to reduce the administrative burden. “The great hope is this: If you look at how a physician or nurse spends their day in a hospital, we have them doing 25% to 30% of their work actually providing direct patient care and 70% to 75% doing administrative work,” he says, adding that those percentages need to be reversed. “I think physicians and nurses, that resonates with them: ‘I want to be back with [patients], doing clinical care,’” he says. The administrative work “has taken away their passion and fire for providing care—that mission people felt called to do. ... [Clinicians] didn't sign up to be a physician or nurse to chart all day.”

Loma Linda's moves on various fronts have helped keep turnover between 3% and 4% below the California state average, although the rate is higher than it's been historically, Wright says. “I don't know that at this point, I'd say we're where we need to be,” he says. “It's too early to point to results directly from this. We win in this when professionals feel, ‘I'm doing the work only I can do. I know why I do this work. I'm spending time doing the work I want to do—caring for people.’ Administrators need to figure out, ‘What can we take off their plates?’”

Ed Finkel is a freelance writer based in Chicago.

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Susan A. Reeves, EdD,
RN, CENP

Safeguarding Our Workforce

Executives have a duty to mitigate threats to staff members' well-being.

Along with many of the pressures seen during the pandemic's height, the need to enact crisis standards of care has, thankfully, abated. Yet, one of the ethical principles included in many organizations' crisis standards of care documents seems more relevant than ever today: the ethical duty to safeguard the healthcare workforce. Why is this an ethical issue? A healthcare organization's mission is to provide high-quality, competent care to those served. To do this, the organization's professionals must be able to experience both physical and psychological safety while meeting patients' needs. In this way, a healthcare organization's duty to care necessarily extends to those served as well as to those doing the serving.

At the pandemic's onset, the rationale behind safeguards, such as prioritizing personal protective equipment, was to maintain healthcare workers' strength so they could provide care to the thousands of patients who would be impacted by pandemic-related illnesses. Today, nurses, physicians, technicians and support staff are in increasingly short supply, and the forces that threaten the safety and vitality of these precious resources continue to multiply.

Some threats are well-known to the industry and, therefore, have strong,

evidence-based mitigation strategies. Examples include management of blood-borne pathogen exposure, back and repetitive motion injuries, and exposure to stressful situations. Other threats, however, though certainly present prior to the pandemic, have escalated dramatically during the past few years, requiring healthcare organizations to double down on their duty to protect their workforce. Following is a look at some of the more urgent threats and related ethical issues.

Today, nurses, physicians, technicians and support staff are in increasingly short supply, and the forces that threaten the safety and vitality of these precious resources continue to multiply.

Threats Related to Infectious Disease

With the regional and seasonal ebb and flow of COVID-19, healthcare organizations have faced the seemingly endless dilemma of deciding when and for whom infection prevention measures, including mandatory quarantines, should be instituted. The polarizing issue of

mandatory masking not just for healthcare staff but for patients, their families and visitors seems to be in constant debate. And the requirement of up-to-date vaccination as a condition of employment has become a determinant of whether an individual accepts or stays in a job. Facing dire workforce shortages, employers often struggle with knowing the right thing to do in these situations, and individuals' autonomous decision-making conflicts with the duty to protect others, which is one of the most basic of all moral dilemmas.

A proactive approach to many of these tough challenges, which relate not only to the ongoing pandemic but also to future infectious disease threats, is the establishment of a standing interprofessional, interdisciplinary team charged with surveillance, data analysis and policy development. Useful to this group's work is having access to the latest scientific evidence regarding effective preventive measures for and treatment of infectious diseases. A trusted organizational expert who can translate difficult-to-understand choices and terminology can assist executives as they communicate with employees, patients and the community.

Lastly, and perhaps obviously, it is far preferable to create policies, plan organizational responses and draft communications while not in the throes of an active crisis. Reaching out to and collaborating with other local, regional and state organizations provides healthcare organizations access to additional expert resources and reduces the burden of going it alone.

Escalating Workplace Violence

It is impossible to ignore the rise in healthcare-related workplace violence. The causes are multifactorial and have been exacerbated by pandemic-related stressors and the opioid crisis. ACHE and most healthcare-related professional organizations have taken bold positions regarding the sector's responsibility to "treat and take steps to mitigate violence and to advocate for cultures of safety" (see the ACHE Policy Statement "Healthcare Executives' Role in Mitigating Workplace Violence" at [ache.org](https://www.ache.org)).

Many contemporary interventions are aimed at this workforce threat. Healthcare organizations are investing in education for their employees and communities regarding the public health impacts of violence. Many have posted signs in their facilities regarding expectations for respectful communication and behavior. Training for all staff on how to recognize and mitigate workforce violence has become commonplace, and steps to make facilities more secure (access restrictions, patient and visitor screening, augmenting security staff) are being implemented.

A plan that spells out how to manage patients who display threatening behavior should also include policies and procedures for declining offenders' access to the organization's services. Collaboration between organizational ethics and risk management resources can manage such eventualities.

Creating an organizational committee to monitor occurrence data, review results of all cause analyses when events do occur and implement

targeted mitigation strategies is an important step to keep the workforce safe. This committee's routine reporting—directly to the organization's C-suite and governance body—is critical to ensuring accountability for the workforce's adequate protection.

It is impossible to ignore the rise in healthcare-related workplace violence.

Declining Workforce Well-Being

Pandemic-related workforce stressors and labor shortages have led to a decline in healthcare worker well-being. Whether the stressors are external to the job (childcare and schooling disruption, inflation, political polarization) or internal (working short-staffed, negative effects on work teams due to contract labor deployment) and likely a combination of the two, it is clear that the healthcare workforce is suffering. Resignations, presenteeism (when an employee is present at work but not as productive or engaged as usual due to health or other issues), reductions in work hours and callouts (last moment calling off from a scheduled shift) are at an all-time high. The healthcare literature is full of studies describing disturbing levels of stress and burnout among the healthcare workforce.

Fortunately, most organizations already are actively responding to these threats. For example, multidisciplinary wellness committees are examining data specific to their organizations and are creating plans to address workplace-related stressors. Specialists trained to reduce EHR-related workloads are being

deployed to help physicians and advanced practice providers. Innovative methods of providing 24/7 mental health supports are offered to employees for little to no cost. And, strong efforts to introduce programs, services and policies that improve organizational diversity, equity, inclusion and belonging are evident. Healthcare executives have a duty to continue applying efforts and resources to these and other strategies to ensure the physical and emotional well-being of their staff members.

Protecting the Workforce Is Essential to Organizations' Missions

As the necessary policies, procedures and programs are developed to protect the workforce, it is inevitable that ethical questions will arise. Thorny issues such as implementing mandatory immunization or masking policies, terminating a relationship with a patient due to actual or high potential for verbal or physical violence, and prosecuting patients for assaults on staff all raise moral questions that should be addressed by an organizational or clinical ethics committee.

While navigating this challenging time in history, healthcare executives will benefit from continually grounding their decisions and actions in their organization's mission—remembering that the organization exists to provide healthcare to its community. And to do so, it needs to protect its workforce. ▲

Susan A. Reeves, EdD, RN, CENP, is executive vice president, Dartmouth Hitchcock Medical Center, Lebanon, N.H. (susan.a.reeves@hitchcock.org).



William F. "Marty"
Martin, PsyD

Artificial Intelligence Meets DEI

Is it a friend, foe or both?

As a friend, AI holds promise for promoting diversity, equity and inclusion. Yet, as a foe, AI deserves a cautious pause given limited data availability, algorithmic biases and lack of AI literacy. This technology has so much potential to both benefit and harm society that the Biden administration announced new actions to promote responsible AI innovation to protect Americans' rights and safety.

Given these dual paths, I see four use cases for this technology in driving DEI: descriptive, diagnostic, predictive and prescriptive. Descriptive explains what has happened: pulling a report describing preferential hiring or promotion practices based on factors irrelevant to predicting future performance. Diagnostic helps to understand why something happened:

identifying "pockets" in the organization with higher complaints/claims of discrimination. Predictive shows what is likely to happen, often based on probabilities: informing a decision to fund one type of DEI training versus another. Finally, prescriptive recommends decisions and actions: uploading a job announcement to detect any gendered and/or racialized language and then automatically correcting it.

AI as a Friend of DEI

AI can be used to inform more objective decision-making based on past data rather than on surveys, focus group insights, expertise, C-suite and board members alone. For instance, leveraging AI to recognize the optimal combination of skills for specific roles rather than solely relying on the hiring managers.

Similar to how orchestras rely on blind interviewing, AI algorithms make decisions based on competency and skill sets that are required for jobs without knowing information about applicants that is not job related such as hair style. These tools can also be used for more objective decisions regarding promotions and compensation. Given the labor shortages confronting healthcare today and high voluntary turnover, AI can also provide predictive power regarding which employees are more likely to be retained and what factors are driving voluntary turnover among high performers.

AI as a Foe of DEI

Algorithmic bias is the most well-known risk of using AI because it has the potential to perpetuate existing biases. Remember, AI is only as good as the data that it is trained on. This caution embodies the adage "garbage in, garbage out." Another risk is a mismatch between the AI literacy of the team selecting vendors and evaluating the impact that AI technology has on DEI. A related risk, especially among DEI and HR practitioners, is that AI will be used primarily as an efficiency tool to address a high workload and administrative burden

Blind Interviewing: Color Blindness vs. Multiculturalism

Blind interviewing is not without controversy and requires deliberation among those making these hiring and promotion decisions. Past research reveals the tension between hiring based on knowing, valuing, appreciating and factoring into the selection process the identity of the candidate (i.e., multiculturalism) versus not having access to this demographic, identity and social categorization data (i.e., color blindness).

Blind interviewing appeals more to some groups than others, may decrease sensitivity to preferential hiring

based on identity and social categorization, and regard systemic and institutional racism as nonexistent. On the other hand, a multicultural approach to interviewing may result in pigeonholing candidates for certain industries, companies, departments and roles, and may increase a perceived threat among others who fear they will not be selected based on merit. Like other complex realities, there is no simple answer, which is why an intentional series of deliberate dialogues must be taken among the board and C-suite.



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rather than as a tool to drive the strategic outcomes of a DEI initiative.

With that, here are three suggestions for leaders considering the use of AI to promote DEI in their organizations.

Proceed with caution. Any AI efforts should be grounded in ethics, focused on strategy and results driven. It is imperative to align AI with each DEI stage of the DEI Maturity Model. Ella F. Washington, PhD, professor of practice at Georgetown University's McDonough School of Business, developed the DEI Maturity Model in an article that appeared in the November/December 2022 issue of *The Harvard Business Review*. Washington says there are five stages from least to most mature: aware, compliant, tactical, integrated and sustainable. Leaders within and outside of DEI ought to consider planning AI into DEI work at the tactical stage but robustly infusing AI at the integrated stage.

Beginning with the compliant stage, AI would be deployed in a way to minimize legal and regulatory risks. At the tactical stage, AI tools would be leveraged to make meaning of existing patterns (descriptive). At the integrated stage, AI tools would be leveraged to attribute causality or gain insights (diagnostic); to advise decisions and cost and resource allocations (predictive); and to make tailored recommendations for patients, employees and the community specific to the organization (prescriptive), assuming a robust data infrastructure and skilled workforce in AI. Finally, at the sustainable stage, AI would be “hard-wired” into the way the organization operates and used as a tool to augment and enhance human decision-making, and also to drive efficiencies.

Mitigate risks by data mine sweeping. To mitigate risks, organizations must first know what possible risks exist across the landscape: legal, regulatory and reputational. Legal risks could range from malpractice suits to discrimination suits. Regulatory risks could include not complying with emerging guidance on AI from the Equal Employment Opportunity Commission. And reputational risks could arise from postings on a company ratings website about the use of AI related to processes, decisions and perceptions of how diverse workers are treated. Remember, the status quo is not risk free. As such, move forward but be equipped with knowledge about incorporating AI into the organization's enterprise risk management framework.

AI can also be used as a DEI enterprise risk management tool. This can be done by creating a centralized repository of data that could even remotely have an impact on DEI, and then mining for any patterns that may arise but without first forming any hypothesis. This is particularly the case with unstructured data, such as incident reports, hotline complaints and exit interviews, in contrast to structured data such as surveys and turnover reports.

Build a robust network of internal and external AI experts. Healthcare leaders do not need to be an expert in AI and DEI to effectively, efficiently and ethically deploy this increasingly everyday technology and soon-to-come enterprise solutions to advance the DEI agenda at their workplace. Internally, DEI can be further resourced, supported and scaled by automating DEI tasks such as audits, analysis and even reporting using generative AI tools such as ChatGPT.

Externally, the use of AI tools from vendors can also advance the organization's DEI strategy as well as do some of the heavy lifting if under-resourced or faced with competing priorities.

Before signing a contract with an AI vendor, carry out due diligence and even conduct a premortem, asking questions such as the following:

- What may go wrong and how can I minimize or prevent that from occurring?
- How did I train the AI model? What data did I use? How do I know the data used to train the model does not have existing biases?
- What is the accuracy rate of my predictive models? How did I measure this?

These questions, although not exhaustive, are a way to engage in a smart way with AI vendors and to ensure that the organization is using the right tool for the right reason at the right time for the right investment.

In essence, the integration of AI into DEI initiatives demands a cautious yet proactive stance. As organizations move forward into an era of AI-driven decision-making, being grounded in ethics, focused on strategy and committed to driving positive results will be pivotal for realizing the full potential of AI as a force for diversity, equity, inclusion and health equity. ▲

William F. “Marty” Martin, PsyD, is professor of Management & Entrepreneurship, faculty director, and Research & Innovation Leadership Fellow at DePaul University, Chicago (martym@depaul.edu).

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Lisa Shoopman

Improving Food Service

Centralized approach results in enhanced patient experience.

Hospitals see a great deal of potential in food service automation to save time and money but more importantly to keep pace with patients' diverse meal preferences. In fact, 90% of surveyed hospital decision-makers say meal service has a direct impact on patient experience, and about half say they are pursuing automation initiatives, according to a recent study by CBORD Insights. Survey respondents cited several potential benefits, but an interest in increasing food service revenues topped the list—a finding that fits with the tight budgets and rising costs hospitals face today.

In Kentucky, Baptist Health is among those organizations implementing food service automation, and the experience has shown that it can enhance the patient experience while at the same time increase revenue.

Automation is a powerful tool for food service operations. But, like any tool, its effectiveness depends on how it's used. For Baptist Health, the key to success has been a focus on two basic principles—centralization and data-driven decision-making—and using them to rethink the way food service operates.

The Power of Centralization

Baptist Health operates eight owned hospitals throughout Kentucky and southern Indiana. Up until a year ago, just three of these had some degree of food service automation in place and essentially ran independently. The rest relied on manual processes such as paper food orders, spreadsheets and printed reports. The health system knew it needed a change, so, in a phased approach during 2022 and 2023, it replaced this fragmented approach with centralized enterprise technology. This single food service solution automates point-of-sale, menu planning and patient ordering processes across all Baptist Health hospitals.

Implementation quickly reduced the inefficiencies inherent in the previous fragmented approach. But its impact has gone far beyond the streamlining of specific tasks. The technology enabled the centralization of food service management. This, in turn, opened the door to new ways of working that have resulted in better controls, reduced redundancies and waste, increased standardization, greater economies of scale, and improved inventory tracking.

Another key benefit of centralization is the ability to bring data together into one database versus multiple

local databases used previously. In that fragmented approach, with pricing at various Baptist Health cafeterias and coffee shops being managed locally, pricing varied from site to site and would often be suboptimal across the hospital system. Now, the single database gives decision-makers a holistic view of costs and retail sales. This has enabled the organization to optimize pricing and make it consistent, helping to increase sales and protect margins.

Automation has helped Baptist Health not only increase revenue but simultaneously improve the customer experience and increase efficiency.

At the same time, centralization has allowed Baptist Health to employ a registered dietitian to monitor and maintain the database. Because the dietitian has a perspective on both clinical nutrition and desired outcomes, this approach has proven to be more efficient, helping to ensure data is used effectively to meet the needs of the food service department and patients.

Having a single database also supports the use of analytics tools to better understand operations, trends and performance, as well as to

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uncover opportunities to increase revenue. Previously, food service directors and executives saw only sporadic, rolled-up metrics. Now, they can view centralized monthly food and nutrition reports that track financial, quality and other metrics. These reports provide a foundation for identifying potential improvements and determining the operational and cultural changes that can enable better performance.

With centralized meal planning and control, along with the increased efficiency of automated food service processes, Baptist Health has revamped room service and retail menus. It can now cost-effectively offer a wider range of options, including more international meals, numerous plant-based offerings and traditional comfort foods such as turkey and meatloaf. This helps the health system stay in step with patients' increasingly diverse meal preferences, which in turn increases sales in the health system's eateries. At the same time, the centralized system makes it possible to track food orders and use these data-driven insights to tweak offerings and help ensure Baptist Health keeps up to date with consumer preferences.

Baptist Health's technology also opens the door to additional revenue opportunities; with a centralized platform, it is relatively easy to bring on new tools and capabilities. For example, Baptist Health is exploring moving to room service ordering for patients and their guests. Implementing this program will improve patient experience and decrease food cost. More than that, by offering restaurant-quality food that visitors want to purchase—and

will purchase—these meals become not only an increased convenience for guests but also provide a source of additional revenue.

The technology enabled the centralization of food service management.

Soon, the health system will also offer mobile ordering, allowing patients and visitors to access menus and place orders on their own without staff assistance—a key benefit in an era of staff shortages. And those staff members will also be able to use their cell phones to place cafeteria orders in advance, quickly pick up their food and pay automatically via payroll deduction. For busy health-care workers, this will help them make the most of their break times; for the hospital, this type of convenience will help increase revenue.

The Broader Payoff: A Better Patient Experience

Boosting revenues is just part of the story. As it has done in other industries, automation has helped Baptist Health not only increase revenue but simultaneously improve the customer experience and increase efficiency to keep costs down.

Patients, of course, are seeing wider choice and convenience in meal service. But the technology also plays a role in patient safety and wellness. Food is critical to helping patients recover, and if they have food that they like, patients will eat well, which contributes to shorter hospital stays and fewer readmissions, according to research published in the March 2022 issue of the journal

Exploratory Research in Clinical and Social Pharmacy. In addition, the Baptist Health food service technology is integrated with the health system's central EHR. This makes it possible to tailor meals to individual dietary requirements related to allergies and medical needs, and to adjust meals as patients move through the continuum of care.

Integration with the EHR also leads to operational benefits. Historically, food service operators did not always know when a patient was discharged or moved to another unit. As a result, meal trays would be delivered but left unused, something that happened with up to 10% of the 48,000 meals per week delivered throughout the eight-hospital system. Now, because of the EHR link, the system automatically “knows” when patients have left, stopping the scheduling of meals for those individuals. This means less wasted food and less time spent unnecessarily moving and cleaning trays.

Finally, a centralized, data-driven approach to automated food service has the potential to enhance a hospital's brand. Indeed, 77% percent of patients in the CBORD Insights survey said that meals would influence their choice of hospital in the future. With the right approach to automation, healthcare organizations, like Baptist Health, can help ensure food service plays a role in building and maintaining a great reputation. ▲

Lisa Shoopman is associate vice president of food and nutrition services at Baptist Health, covering Kentucky and southern Indiana (lisa.shoopman@bhsi.com).



Paul H. Keckley, PhD

Health System Public Opinion

How beliefs and attitudes have changed, and what they mean.

Trust in the U.S. health system is at an all-time low, as two recent polls illustrate the public's declining confidence in the institution.

The majority (66%) of adults in 2022 said they have little or no confidence in the system—up from 20% in 1975, according to the July 2023 Gallup poll *Historically Low Faith in U.S. Institutions Continues*. The majority (65%) believe the system prioritizes profit over patient care, and only 20% trust healthcare leaders “a great deal” or “a lot,” according to research conducted by communications firm Jarrard that was published in October.

increasingly problematic for physicians, hospitals and other health organizations.

The Unique Challenge of Public Opinion

For the vast majority of Americans, attitudes about the U.S. health system are based on personal experiences often shared with others. They're based on the hospitals, doctors, prescription drugs and insurance coverage they or family members elect to use. They're not based on a studied view of the system nor formal education in primary, secondary or higher education. The underlying beliefs on which attitudes about specific health issues are anchored originate from an individual's socialization (religiosity, family structure, local circumstances, household income) and change slowly. Only a major event or personal experience (such as a loss of insurance coverage, a new diagnosis or a surprise medical bill) prompts consumers to rethink these deeply held core beliefs.

Thus, attitudes about the health system are based on a gestalt assessment of its complexity and personal circumstances in navigating it effectively.

As reported by Gallup in July 2023, confidence and trust in U.S.

institutions has declined across the board: All of the 16 institutions it measures have seen decline since 2021, with the U.S. presidency falling 12% (from 38% to 26%) followed by the “medical system,” which lost 10% (from 44% to 34%). Only two institutions, small business (65%) and the military (60%), enjoy majority trust and confidence, while the medical system ranks fourth overall on the list just behind “the police” (43%).

What makes public opinion about the health system unique is its ubiquitous presence on television via advertisements; social media commentary; facilities and clinicians in every community; investigative reports about fraud and bad actors via traditional media; political rhetoric about its performance; and out-of-pocket costs for co-pays, deductibles and what's not covered. Every individual is directly and frequently exposed to one or more sectors in the system every year or more frequently as a user or payer.

Trust in the U.S. healthcare system is more volatile than any other industry, according to the 2022 Edelman Trust Barometer. The Commonwealth Fund's report *Mirror, Mirror 2021—Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* states the U.S. health system is the least trusted of 11 westernized systems it studied.

The high-profile role the health system occupies in traditional and nontraditional media coverage lends to misinformation and erosion of trust. The pandemic exposed the system's disconnect between public

66% OF ADULTS
IN 2022
said they have little or no confidence
in the system—up from 20% in 1975.
Source: Gallup

Kaiser Tracking Polls, Pew Research, Commonwealth Fund and Edelman Trust surveys show similar results: The majority of Americans, especially those in lower income, disabled and ethnic minority populations, have a negative view of the system. Though opinions about its accessibility, affordability and effectiveness vary widely, disaffection is widespread and

health, nursing homes and local hospitals and lent to misinformation about the efficacy of its vaccines and the trustworthiness of the Centers for Disease Control and Prevention and government. Notably, institutional trust plummeted.

Building, maintaining and rebuilding trust requires purposeful investment.

Most provider organizations rely on well-orchestrated communications programs and word of mouth.

Implications for Provider Organizations

For medical groups, hospitals, post-acute providers and their support services, erosion of trust in the health system endangers the morale of its workforce and compromises patient outcomes. In fact, studies show a direct correlation between a patient's confidence in a trusted provider and adherence to evidence-based directives.

At the community level, distrust of the health system is manifest in sub-optimal public health outcomes and higher costs. Distrust prompts many to delay treatment or suffer when remedies were available.

Building, maintaining and rebuilding trust requires purposeful investment. Most provider organizations rely on well-orchestrated communications programs and word of mouth, user satisfaction surveys (such as Net Promoter Scores,

Hospital Consumer Assessment of Healthcare Providers and Systems) and employee education to build and maintain trust. Notwithstanding whistleblower complaints, egregious medical errors, executive malfeasance and other lapses, trust and confidence for most is manageable.

But in the marketplace today, more attention is needed. New and enhanced investments are essential in four areas:

- **Misinformation mitigation:** Sustain a heightened vigilance and proactive mitigation of sources of misinformation or disinformation that could be harmful to the organization.
- **Data-sharing and transparency:** Deliver increased, targeted messaging to trustees, managers, key elected officials and community leaders specific to pain points frequently exploited by critics such as executive compensation, community benefits and pay equity. Note: verifiable data must be provided in an objective context.
- **Media relationships:** Maintain direct lines of communication with influencers in the media. Responsiveness, objectivity and transparency in meeting their needs is essential to getting fair, accurate and balanced coverage.
- **Formal education:** The health system is the nation's biggest employer and 18% of the nation's economy, yet its navigation is left to people who are ill-equipped to manage its

complexity. The nation's leaders in secondary and higher education should develop curricula to hardwire in its citizens an understanding of the health system and measures of competence in its navigation.

Trust is built through the cumulative good work performed by institutions known for integrity, fairness and purpose. It is destroyed by a single act. The gradual erosion of trust in the U.S. health system is understandable given societal trends and the economic realities of the industry. ▲

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

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have the opportunity to provide feedback, give voice to the plan and help us identify what's next for leaders in healthcare. We look forward to hearing your ambitions for yourself, our professional community and the field. Healthcare is always evolving, and ACHE is here to evolve with it. In doing so, we are committed to doing our best for you and look forward to all we will achieve together this year. ▲

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



Roxanne Aldi-Quaresima, APRN



Robert M. Weiss

Building Career Pathways

Strategies for addressing clinical and nonclinical staffing shortages.

In 2020, there was no textbook for healthcare organizations to follow on how to handle the COVID-19 pandemic and the resulting nursing shortage. Healthcare institutions across the country had to be proactive, focusing on innovation, adaptability and, most importantly, resilience.

These foundational relationships allow young adults to learn about healthcare careers, resulting in an innovative recruitment strategy.

Since then, staffing shortages have persisted across all care disciplines. Throughout this time, Hartford HealthCare's Central Region didn't wait for the issue to get worse. The New Britain, Conn.-based organization took proactive steps to address staffing shortages and reverse the trend.

A Two-Pronged Approach

To begin addressing staffing shortages, Hartford HealthCare's Central Region created a pathway to network and build relationships with local communities. A

multidisciplinary group of leaders from across the organization worked together to build a strategy that would better integrate and build relationships with the local communities it serves. As a result, students and staff from local high schools and community group officials became familiar with the healthcare team and how the organization functions. These foundational relationships allow young adults to learn about healthcare careers, resulting in an innovative recruitment strategy that is two-fold: a focus on operations for ancillary departments and on nursing. The core objectives were to provide avenues for young adults to explore and experience different areas within the hospital.

Operations Pathway

The first pathway, the General Operations Associate program, provides career opportunities for individuals interested in the healthcare field outside of nursing. The program's overarching goal is to train young adults in multiple departments, which promotes broad exposure to areas such as environmental services, food and nutrition, and transport. This approach targets departments with historically higher staff turnover and position vacancies and gives young adults

the opportunity to get a job and work within the acute care setting. The program is budget neutral, meaning employees backfill vacant positions, and their hours are billed to the departments in which they work. In addition, most of the program participants work per diem, and there are no additional benefits.

Since the program's inception in August 2022, general operations associates have covered more than 1,500 hours per month, all which would have been left unfilled and resulted in staff vacancies or overtime. As a result, departments have reduced their overtime by 12% and have significantly reduced callouts (employees who are scheduled to work but call in on the day of saying they won't be coming in) due to staff burnout. In addition, Hartford HealthCare Central Region's employee engagement survey participation increased by 11%, with 93% of respondents stating their

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work is meaningful and employees reporting that their departments are adequately staffed.

Hartford HealthCare also created another operations recruitment program. Through its internship program for inner city young adults, participants work in various clinical and nonclinical departments, providing a pathway to long-term healthcare careers. Students gain valuable experiences in the acute care setting in areas including nursing, rehab, radiology, marketing, IT and guest relations. These opportunities provide students with first-hand exposure to careers in healthcare. Since the program's inception, there have been more than 50 interns across three cohorts, with new cohorts and additional departments slated for the 2023–2024 school year, which started in November.

To begin addressing staffing shortages, Hartford HealthCare's Central Region created a pathway to network and build relationships with local communities.

Nursing Pathways

Hartford HealthCare's second pathway for addressing staffing shortages involves nursing through a partnership with ReadyCT, an organization that provides career opportunities for students. The goal is to work with young adults who are completing their certified nurse's aide course or those who

show interest in nursing. ReadyCT staff or Hartford Healthcare staff work closely with young adults from ReadyCT, giving them exposure to clinical operations and helping them learn key skill sets to enhance their professional careers. Those interactions and experiences are proving to be invaluable to the students.

Hartford HealthCare's Central Region Nursing Professional Development team has created a nursing student advanced pipeline, which supports young adults who are starting in a nursing program and seeking clinical opportunity on their nursing journeys. The pipeline, started in 2020, is flourishing; since 2021, Hartford HealthCare has recruited 59 patient experience assistants and 137 student nurse techs. In addition, the program has supported 50 student nurse interns with a 50% retention rate of hiring graduate nurses.

Hartford HealthCare is extremely proud of the efforts it has undertaken since the start of the pandemic when it comes to caring for its patients and looking for creative and meaningful ways to stay ahead of staffing challenges. Doing so allows the organization to continue to offer a high level of quality care to its communities, no matter the circumstances. ▲

Roxanne Aldi-Quaresima, APRN, is director of nursing, Hartford HealthCare, New Britain, Conn. (Roxanne.Aldi-Quaresima@hhchealth.org). Robert M. Weiss was regional business operations manager, Hartford HealthCare, New Britain, Conn. He is an ACHE Member.



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Kedar Mate, MD

Healthcare Safety Needs Radical Collaboration

Data-driven stakeholder cooperation can help produce proactive solutions.

The state of patient and workforce safety is concerning. COVID-19, though declining, remains with us and has created financial turmoil for health systems, supply disruptions and formidable challenges to workforce morale. National patient safety reports show that while we have made progress in certain areas, there have also been significant setbacks. We still face major headwinds to the overall improvement of safety across our healthcare systems.

Though these findings appear bleak, there is still cause to celebrate the work of the patient safety movement. Safety is now a near-universal focal point for every board and leadership team in U.S. healthcare. Teams are dedicated to improving safety, and new diagnostics and treatments are regularly and reliably evaluated for it. We now have a common language for this work, one that is taught in medical and nursing schools across the country. Many patient outcomes have improved, from infection rates to medication adverse events to remarkable achievements in managing the pandemic. Some errors that were once common are now rare or never events.

These wins come against a backdrop of ever-increasing clinical

complexity, more powerful (and more potentially harmful) treatments, growing interest in the capabilities of AI in healthcare, and an aging population that experiences more medical errors and harms than ever before. The battle for a safer healthcare system in America is winnable, though we are wise to increase our sensitivity to harm and error even as we work with ever-riskier tools and more complex clinical contexts.

An effective Health Care Safety Team centers patients and their families—who remain underused resources—in the work.

New treatments and diagnostics, novel and more numerous applications of AI, and increasing co-production of healthcare with patients and families carry unimaginable health possibilities for our families and communities. But they also carry new safety risks that we must anticipate, predict, diagnose, mitigate and solve.

We need to move quickly toward a much more proactive and prospective approach to improving safety. Though

this future-looking approach can take many forms, there is already evidence and precedent from other industries of what healthcare systems may require to move toward breakthrough performance in safety and quality.

For example, by the mid-1990s commercial aviation had become much safer. Catastrophic aircraft losses became relatively rare events, yet occasional disasters still occurred, and the overall rate of improvements in aviation safety plateaued. At that time, regulators and industry experts set aside their competitive interests to collaborate on safety improvement, recognizing that any aviation disaster would be devastating for the whole industry. Inspired leaders established the Commercial Aviation Safety Team, or CAST, an organization dedicated to improving aviation safety worldwide and, importantly, worked to link government agencies, aircraft manufacturers, airlines, pilot unions and other industry stakeholders. CAST operated from a data-driven approach, using aviation incident and accident data analysis to identify common safety risks and develop targeted solutions that needed multiple stakeholders to implement.

When CAST began, many in the aviation industry believed we had reached the apex of aviation safety. What happened next is remarkable: a further 83% decline in fatality risk in commercial aviation. Flying today is far safer than it was in the 1990s, even as many more of us have taken to the skies. CAST achieved this incredible feat by unifying data systems, fostering real collaboration and promoting a proactive approach to safety.

Establishing a similar entity could help healthcare break through the current plateau in safety. We could call it the Health Care Safety Team—a voluntary, data-driven stakeholder collaboration that seeks proactive solutions to patient and workforce safety challenges. Fortunately, federal partners and advisers in the U.S., including the President’s Council of Advisors on Science and Technology, are coming to similar conclusions about the need for a national-level focus on patient safety.

.....
Another goal of the Health Care Safety Team could be to enable clinical systems to use real-time, proactive data to create greater situational awareness and to anticipate and mitigate risks.
.....

So, what might a Health Care Safety Team look like? It could share many similar elements to those in CAST, but one distinguishing characteristic is the crucial engagement of patients and families. An effective Health Care Safety Team centers patients and their families—who remain underused resources—in the work; they are the primary and most crucial detectors of risk and potential deterioration and essential participants in the co-production of clinical improvements and outcomes.

The Commercial Aviation Safety Team broke new ground by moving from competition to collaboration and by building and leveraging new relationships across stakeholder

groups. A Health Care Safety Team could go even further and rely on a “radical collaboration.” Such collaboration starts with centering patients and their families, but it also requires engaging every part of the health system and using emerging technologies—especially AI—to both support and augment the efforts of stakeholders. It is becoming increasingly possible for novel AI-driven algorithms to help identify signs of clinical deterioration, adverse drug events, risk for falls and pressure injuries, and to improve disease management for whole populations. A critical step in the next few years will be to ensure that new knowledge generated by those algorithms can be matched by delivery system improvements to help clinicians act on these insights to protect the health of our patients.

One of the best ways to use this new knowledge to design and implement real improvements in care delivery is to create and nurture large-scale learning networks. These networks typically connect clinicians, researchers, patients and families in a single network to ensure that what we study is what matters to patients, and what we discover gets rapidly implemented in clinics and hospitals. It’s the same principle of collaboration that would drive the Health Care Safety Team—each stakeholder group already has a critical role to play in ensuring safety, but continuing to work separately will achieve the safety results we have always gotten, and that’s not good enough.

Another goal of the Health Care Safety Team could be to enable clinical systems to use real-time, proactive data to create greater situational

awareness and to anticipate and mitigate risks. Data from individual clinical settings, the condition-specific learning networks, and the larger network of the Safety Team could all be combined so AI-driven algorithms could instantly detect patterns and signals.

Lastly, undergirding this new kind of radical collaboration is the restorative, just culture necessary for lasting safety improvements. The progress made to date by the patient safety movement has revealed the key cultural elements needed to both prevent adverse events and effectively learn from them: true accountability without blame or shame, emphasizing curiosity over judgment, and effective communication and resolution programs. Together, these elements allow patients, families and clinicians to learn from adverse events and to heal.

Aviation industry leaders that formed CAST in the 1990s understood that despite significant improvements in safety, better was not enough. CAST was created to pursue perfection, to set a goal of making commercial aviation completely safe. We require the same for safety in healthcare. Perfection in healthcare may be out of reach, but as legendary Green Bay Packers coach Vince Lombardi said, “We will chase perfection, and we will chase it relentlessly, knowing all the while we can never attain it. But along the way, we shall catch excellence.” ▲

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



Darrell K. Terry Sr.,
FACHE

A Commitment to Local Investment

Newark Beth Israel's effort to source and recruit area talent is paying off.

The National Academy of Medicine defines social determinants of health as all the health-related behaviors, socioeconomic and environmental factors that impact the health outcomes of a community. The academy also notes that 80% of health outcomes are impacted by social determinants of health. That is why Newark Beth Israel Medical Center, a 665-bed regional care teaching hospital and a vital economic engine in the city of Newark, N.J., is committed not only to delivering world-class care to the patients it serves but also addressing those social determinants of health and improving the socioeconomic status of its surrounding communities.

As one of the largest employers and an anchor institution in Newark, Newark Beth Israel has been serving the city since 1901 and, specifically, the city's South Ward, which is where the organization has been located since 1928. To create a healthier community, Newark Beth Israel goes beyond what its physicians and clinical teams offer inside the hospital to address the social determinants of health for people in the community. To accomplish this endeavor, it's important that the CEO works closely with the senior leadership team to develop initiatives that address a range of social

determinants, including job creation, career advancement, local investment and procurement, and food security programs.

Hiring Local

Unemployment and underemployment are two social determinants of health that the organization has committed to addressing through local hiring, creating career development opportunities and supporting local businesses.

Working in partnership with the community relations department, Newark Beth Israel Medical Center's human resources team identifies opportunities to participate in local health and job fairs. The organization also hosts weekly open house sessions, where residents are encouraged to walk into the hospital to interview for a variety of open positions such as registered nurses, nursing assistants and roles in environmental services. In addition, Newark Beth Israel collaborates with its healthcare system, RWJBarnabas Health, the largest and most comprehensive academic healthcare system in the state of New Jersey, to participate in job fairs across greater Newark.

Newark Beth Israel Medical Center has also created initiatives to help employees advance their careers.

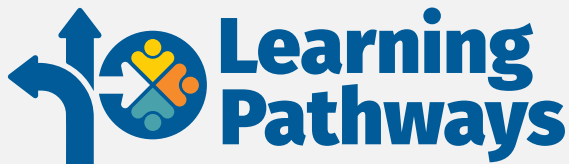
For example, it is partnering with Fairleigh Dickinson University, which has campuses in northern New Jersey, to offer qualified candidates a Master of Public Administration degree with a specialization in health-care management. To increase access to this program for all interested employees, the courses are offered on weeknights and on-site at the hospital. Although it is a two-year program, employees can enhance their resumes with an MPA certificate after completing the first six courses in the program.

Newark Beth Israel Medical Center is partnering with Fairleigh Dickinson University to offer qualified candidates a Master of Public Administration degree with a specialization in healthcare management.

The Career Ladders initiative also provides Newark Beth Israel Medical Center employees with free education and training opportunities at colleges across New Jersey. Through this program, employees may earn an associate degree from an accredited New Jersey community college of their choice.

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Newark Beth Israel is also creating a pipeline for young local residents to join its team. Partnering with the city of Newark and the local high school's Allied Health Program, the organization is facilitating summer youth employment opportunities at the hospital. The program provides high school students with short-term, meaningful work assignments designed to enhance their employability skills.

Investing in the Community

Newark Beth Israel provides world-class care close to home for thousands of Newark residents. It is home to one of the nation's top 15 heart transplant centers, which has performed more than 1,100 heart transplants. It is also home to New Jersey's only advanced lung disease and transplant program and a valve center that performs complex cardiac valve procedures, including minimally invasive transcatheter aortic valve replacements.

In addition, *Newsweek* has named the organization "World's Best Hospital" five consecutive times as well as a "Best Maternity Hospital."

However, until recently, the outward, brick façade of the hospital did not truly represent the excellent care being delivered within the hospital walls.

In 2021, Newark Beth Israel embarked on a transformative expansion of its facility. Dubbed the Newark Strong Project, it is the largest investment in the facility and local community in the last 50 years. Through the project, the organization is investing \$150 million in physical improvements to support the delivery of excellent patient care and an enhanced experience for both patients and

visitors, such as a new 17,500-square-foot, glass-enclosed lobby; expanded adult and pediatric EDs; new operating rooms and cardiac catheterization labs; a new, state-of-the-art geriatric unit; and a new cardiothoracic ICU.

Furthermore, the project is also generating economic growth and creating opportunities for local, small and minority-owned businesses.

For example, the organization contracted with a construction firm committed to engaging with the community, including hiring local Newark residents and contracting with local vendors for daily lunch service and large-scale special events.

In addition, Newark Beth Israel has invested 30% of its entire investment into local businesses owned by women, minorities and veterans. In fact, all the glass in the new lobby was installed by a local women-owned business.

Addressing Food Insecurity

Newark Beth Israel and RWJBarnabas Health have also initiated several groundbreaking programs to address food insecurity.

For example, the Beth Greenhouse is the only hospital-based hydroponic greenhouse of its kind in New Jersey to offer fresh, locally grown produce to nearby residents. Hydroponic farming is a highly productive, environmentally friendly and space efficient means of farming, saving water, eliminating agricultural runoff and chemical pesticides and offering year-round food production.

The Beth Greenhouse produces more than 5,000 pounds of fresh produce

every year using a continuous flow of nutrient-rich water that is recirculated in the system. The produce is then sold at the greenhouse during a weekly farmer's market, delivered to the hospital's Women's Wellness Pantry and used to teach healthy cooking at the Reverend Dr. Ronald B. Christian Community Health and Wellness Center.

In addition to providing fresh food access, the greenhouse serves as an educational space where local schools can host field trips and community groups can offer tours.

The Women's Wellness Pantry, which Newark Beth Israel and RWJBarnabas Health opened in 2019 at the Reverend Dr. Ronald B. Christian Community Health and Wellness Center, aims to improve the health and well-being of pregnant women, new mothers and their families. The pantry provides a variety of healthy food items, fresh produce, and personal hygiene products and diapers. Families also receive health and nutrition education.

Newark Beth Israel's concerted effort to source and recruit local talent is paying off. To date, approximately one-quarter of the 3,300-employee workforce is local hires.

The organization remains committed to continued investment in its family: the employees, patients and community members who call Newark Beth Israel home. ▲

Darrell K. Terry Sr., FACHE, is president/CEO, Newark Beth Israel Medical Center and Children's Hospital of New Jersey, RWJBarnabas Health, Newark, N.J., (darrell.terry@rwjbh.org).



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Steven M. Berkowitz,
MD

The Evolving Role of the CMO

Four challenges and solutions for continued success.

The role and scope of the CMO has transitioned and matured considerably over the past 30 years. Very few hospitals had a position of a senior medical leader, and the concept of “Let the doctors practice medicine and the administrators run the hospital” prevailed. But hospitals and evolving healthcare systems rapidly recognized the need for physician leadership at the senior administrative level. Physician executive positions came to be seen as not only valuable but also indispensable to the future of the organization.

Despite giving up the practice of medicine, effective CMOs take pride in knowing that their administrative achievements contribute to the overall improved care of patients.

The CMO became an integral member of the senior management team, with a unique opportunity to bring the needed medical expertise to the decision-making table. The trend of increasing responsibilities will continue. The successful CMO will have to personally evolve to keep pace.

The following are four challenges that a CMO will likely encounter through the course of a very rewarding career.

1. Master interpersonal and business skills not taught in medical school or encountered in the practice of medicine. In addition to the clinical arena in which the physician is typically very comfortable, the CMO must now thrive and grow in the business environment, with different rules and expectations. Many practicing physicians who choose administrative positions had no inclination they would do so when they were medical students or residents—or even in clinical practice. In the C-suite and boardroom, they are now surrounded by a team that has typically had much more knowledge and experience in the business aspects of the organization. To be a successful leader, the physician must learn business skills that were likely never taught during that physician’s original training.

The CMO is part of a team and must participate in shared decision-making and negotiations, a new challenge for many physician executives. Fortunately, in recent years, the practice of medicine has also recognized the value of shared decision-making among the clinical care team, but this was not typically the case.

Because of the different skill sets required, the best clinician does not necessarily make the best CMO. The outcomes of administrative decisions may not be as straightforward as making a diagnosis based on a patient examination. A successful hospital safety program designed primarily by the CMO, for example, may achieve a substantial clinical result, but the success of the initiative cannot be drilled down to a specific intervention, as with an individual patient. The feedback is usually delayed. Administrative initiatives are on a 30,000-foot level, as opposed to ground-level outcomes with a particular patient. The differences between the clinical arena and business world in many ways are analogous to micro and macroeconomics—very different skill sets.

Thus, the new physician executive often has a learning curve in finance, marketing, decision-making and other fundamental business skills. Many seasoned CMOs believe it takes at least five years on the job to feel comfortable in the new environment.

2. Understand the difficult (and very personal) challenge of giving up clinical practice. As the CMO progresses along the administrative career track, the increasing demands may ultimately require the physician to transition out of direct

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patient care. Along this journey, the CMO begins a measured process of reducing patient care time. Entry-level medical administrative positions are usually part time, and patient care duties may not be substantially affected, but as the scope of administrative responsibilities increase (and the availability of clinical time correspondingly decreases), conflicts will inevitably arise. Most senior CMO positions today now require 100% administrative time.

The administrative and clinical responsibilities cannot be realistically compartmentalized. It is common for a patient to get sick during administrative time or an administrative crisis to arise during the clinical time. Juggling the two responsibilities often results in the frustration of fellow administrators and patients, as well as the individual CMO.

As the physician's patient time decreases, there is the legitimate concern that clinical acumen and skills could be adversely affected. This is especially true for interventional specialists who must maintain a requisite volume of procedures to stay at the top of their game. Except for emergency physicians or hospitalists who can vary shifts per month, there is not a great deal of practical flexibility in reducing clinical time.

Typically, the decision point to end clinical practice comes sooner rather than later, and the CMO may likely reach a point where there is no turning back to clinical work. The issue becomes personal, as the love of practicing medicine, which

brought that person into the field initially, must now be put aside. Fortunately, the CMO role has more than enough challenges. There is plenty of opportunity to immerse oneself in other productive medical endeavors.

Some believe ongoing clinical practice is necessary to maintain credibility with the medical community, but the successful physician executive will maintain credibility through the results achieved as a physician leader.

.....
To be a successful leader, the physician must learn business skills that were likely never taught during that physician's original training.
.....

Becoming an administrator must be seen as a career transition, a change in specialties. Some responsibilities are added, some must be given up. Such may be the fate of clinical practice for the physician executive.

Despite giving up the practice of medicine, effective CMOs take pride in knowing that their administrative achievements contribute to the overall improved care of patients. CMOs continue to "practice" medicine, but on a different level.

3. Maintain competencies related to business, clinical and new technologies. All executives are challenged to keep up with changes that occur in their field. The CMO must maintain a comfort level in three

areas: clinical medicine, business acumen and new, emerging technologies. This is a formidable task.

The business of healthcare is rapidly changing and evolving, and it will only get more complicated and sophisticated. All members of the senior healthcare team must stay abreast of these changes.

On the clinical side, the CMO needs to have a working knowledge of multiple specialties, not just the one in which that CMO initially trained. Most of the time, the clinical issues in the hospital occur in a field where that CMO had little or no formal training, a particular challenge for that CMO.

The CMO is in a critical position to evaluate, prioritize and implement new technologies. As an example, AI has exploded onto the medical scene in the past few years with the opportunity to revolutionize medical care. The CMO must be a major thought leader in the evaluation, selection and implementation of these new and emerging technologies.

Staying current in any one of these areas can be daunting. To be current in all three can require gargantuan efforts on the part of the physician executive, much more than the physician typically had to encounter while in clinical practice.

4. Develop and nurture a health-care network. Like in all leadership positions, decisions made by the CMO can be difficult, and it is not uncommon to feel lonely or not have support systems. During these times, the CMO may miss

the collegiality encountered in medical practice.

Furthermore, administrative decisions that are not popular with the medical staff only feed on the perception that the CMO has truly exchanged the white coat for a suit coat and has abandoned them.

During these times, it is imperative that the physician executive develop and nurture relationships with colleagues. Although every hospital is unique, most challenges that face all healthcare executives are remarkably similar.

Many times, other colleagues have dealt with the same issues. Discussions and collaborations among other executives can lead to mutually beneficial solutions, as well as the ability to candidly discuss a difficult situation.

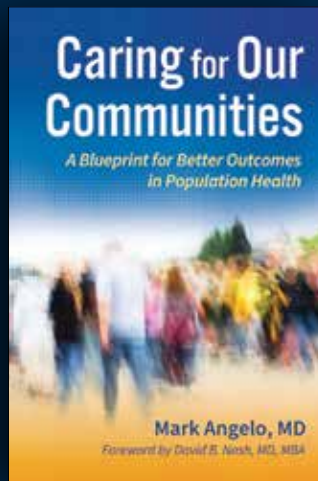
The ability to groom, maintain and use a healthcare network is one of the most important things that a CMO can do to improve decision-making and even maintain a healthy and resilient attitude.

Yes, the CMO has come a long way, and it is even more exciting to look ahead and see where the position will be in the future. The CMO position can be extremely rewarding and challenging. There is new learning and new challenges every day.

Opportunities for collaboration abound. ▲

Steven M. Berkowitz, MD, is chief physician executive at SMB Health Care Consulting, Scottsdale, Ariz. (steve@smbhealthconsulting.com).

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ACHE MEMBER UPDATE

Interim Regent Appointed

Amandeep K. Chawla, FACHE, chief supply chain officer, Stanford Hospital, Palo Alto, Calif., has been appointed Interim Regent-at-Large for District 5.

ACHE Announces Nominating Committee 2024 Slate

The ACHE Nominating Committee has selected a slate of leaders to be presented for approval at the Council of Regents meeting on March 23, 2024. 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 nominees for the 2024 slate are as follows:

In Memoriam

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

Bobby L. Davenport, FACHE
McMinnville, Tenn.

Mikel D. Holland, MD
Pierre, S.D.

Denise Moland, RN, FACHE
Lincoln City, Ore.

Elden Rand, MD, FACP
Sioux Falls, S.D.

Jean A. Tauber, FACHE
Erie, Pa.

Steven Twaddle, FACHE
Fayetteville, N.C.

Donald A. Zinner, FACHE
Islamorada, Fla.

Nominating Committee Member, District 1 (two-year term ending in 2026)

Stephanie M. Meier, FACHE
Associate Vice President, Operations
Northwell Health
New Hyde Park, N.Y.

Nominating Committee Member, District 4 (two-year term ending in 2026)

Lori L. Wightman, RN, FACHE
CEO
Bothwell Regional Health Center
Sedalia, Mo.

Nominating Committee Member, District 5 (two-year term ending in 2026)

Harry C. Sax, MD, FACHE
Executive Vice Chair, Surgery/
Associate Dean for International
Academic Programs
Cedars-Sinai Medical Center
Los Angeles

Governor (three-year term ending in 2027)

Ajani (AJ) Dunn, FACHE
Chief Administrative Officer
Mayo Clinic in Florida
Jacksonville, Fla.

Governor (three-year term ending in 2027)

Wendy M. Horton, PharmD, FACHE
CEO
UVA Health University Medical Center
Charlottesville, Va.

Governor (three-year term ending in 2027)

Alfred A. Montoya Jr., FACHE
Acting Assistant Under Secretary for
Health, Support Services

Deputy Assistant Under Secretary for
Health, Operations
Veterans Health Administration,
Department of Veterans Affairs
Washington, D.C.

Governor (three-year term ending in 2027)

Monica C. Vargas-Mahar, FACHE
Market CEO
Carondelet Health Network
Tucson, Ariz.

Chair-Elect

Michele K. Sutton, FACHE
President/CEO
North Oaks Health System
Hammond, La.

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:

Carrie Owen Plietz, FACHE
 Anthony A. Armada, FACHE
 Jennifer D. Alderfer, FACHE
 Todd A. Caliva, FACHE
 CAPT Robert T. McMahon III, FACHE
 Mark Schulte, FACHE
 Ashley R. Vertuno, FACHE
 Christine C. Winn, PhD, FACHE

ACHE Call for Nominations for the 2025 Slate

ACHE's 2024–2025 Nominating Committee is calling for applications for service beginning in 2025. 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 2027).
- Nominating Committee Member, District 3 (two-year term ending in 2027).
- Nominating Committee Member, District 6 (two-year term ending in 2027).
- Four Governors (three-year terms ending in 2028).
- 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:** Uniformed Services/Veterans Affairs

Candidates for Chair-Elect and Governor should submit an application to serve, 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 krock@ache.org and must be received by July 26. All correspondence should be addressed to Anthony A. Armada, FACHE, chair, Nominating Committee, c/o Kim Rock, American College of Healthcare

Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698.

The first meeting of ACHE's 2024–2025 Nominating Committee will be held March 26 during the 2024 Congress on Healthcare Leadership in Chicago. The committee will be in open session at 2:45 p.m. Central time.

During the meeting, an orientation session will be conducted for potential candidates, giving them the opportunity to ask questions regarding the nominating process. Immediately following the orientation, an open forum will be provided for ACHE members to present and discuss their views of ACHE leadership needs.

Following the July 26 submission deadline, the committee may meet to determine which candidates for Chair-Elect and Governor will be interviewed. All candidates will be notified of the committee's decision no later than Sept. 27, and candidates for Chair-Elect and Governor will be interviewed in person Oct. 17 in Chicago.

To review the Candidate Guidelines, visit [ache.org/CandidateGuidelines](https://www.ache.org/CandidateGuidelines). If you have any questions, please contact Kim Rock at (312) 424-9375 or krock@ache.org.

Call for Proposals: Management Innovations Poster Session

Authors are invited to submit narratives of their posters for consideration for the Annual Management Innovations Poster Session to be held at the 2024 Congress on Healthcare Leadership.

ACHE MEMBER UPDATE

This is a unique opportunity for authors to share the innovative work being done at their organizations with other healthcare leaders.

ACHE is 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 or uses of new technology.

Go to ache.org/CongressPosterSession for the full selection criteria. Narratives should be submitted as an email attachment to PosterSessions@ache.org by **Jan. 16, 2024**.

Registration Open for Diversity Internships

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

Health Equity are pleased to announce that registration is open for the institute's 2024 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 November 2023, registration opened for host sites and students interested in participating in these experiences.

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 Jackie P. Hunter, DC, ND, vice president, Diversity & Inclusion, Executive Office, ACHE, at jhunter@ache.org or (312) 424-9367.

LEADERS IN ACTION

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

Delvecchio S. Finley, FACHE Chair

National Association of Latino Healthcare Executives
6th Annual Leadership Summit
Seattle
(September 2023)

WA-ACHE Fall Conference
Snoqualmie, Wash.
(October 2023)

National Association of Health Services Executives
38th Annual Education Conference
Atlanta
(October 2023)

International Hospital Federation
World Hospital Congress
Lisbon, Portugal
(November 2023)

Noel J. Cardenas, FACHE Governor

Sooner Healthcare Executives Annual Business Meeting
Virtual
(December 2023)

Anthony A. Armada, FACHE Immediate Past Chair

iHEN Annual Awards: Better Together
Whitestown, Ind.
(December 2023)

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Matthew McConaughey *Stand Up To Cancer Ambassador*
Photo by **John Russo**
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PEOPLE

ACHE Chapters Recognized for Their Commitment to Diversity

Five chapters received the 2023 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 healthcare management field. The following chapters received the award during the annual Chapter Leaders Conference, which took place in September in Chicago. For more on the winners, see “Chapter News” on Page 60.

- **District 1:** CT Association of Healthcare Executives.

- **District 2:** ACHE of Georgia.
- **District 3:** Indiana Healthcare Executives Network.
- **District 4:** ACHE of North Texas.
- **District 5:** Arizona Healthcare Executives.

2023 Executive Program: Helping Leaders Advance

In October, nearly 60 healthcare leaders completed ACHE’s 2023 Executive Program, composed of Executive, Senior Executive and Clinical Executive cohorts. This in-person, three-module series was held over four months, with the first module beginning in June 2023 and the two subsequent modules held in August and October.

ACHE’s 2023 Executive Program featured sessions led and facilitated by leading healthcare experts, individualized career coaching, professional leadership assessments and health system site visits 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-person in 2024. More information will be available soon.

ACHE STAFF NEWS

ACHE Staff Members Receive Service Awards**20-Year Service Award**

Christine M. Sawyer, director, Finance & Accounting, Dept. of Business Excellence.

15-Year Service Award

Carla M. Nessa, art director, Dept. of Communications & Marketing.

Emma O’Riley, vice president, Communications and Marketing Operations, Dept. of Communications & Marketing.

10-Year Service Award

Elizabeth M. Villagomez, data analyst, Dept. of Executive Office.

Five-Year Service Award

Christopher Cherry, lead customer service representative, Dept. of Executive Engagement.

Summer A. O’Neill, director, Professional Development, Dept. of Professional Development.

Deneen Y. Wakefield, senior customer service representative, Dept. of Executive Engagement.

IHF Announces 2023 Award Winners

ACHE congratulates the recipients of the 2023 International Hospital Federation Awards. These awards, which include the American College of Healthcare Executives Excellence Award for Leadership and Management, are recognized around the world as the premier awards program to honor hospitals and healthcare organizations. IHF announced the 2023 recipients Oct. 26 and presented the awards during a ceremony at the 46th World Hospital Congress in Lisbon, Portugal, Oct. 25–27.

The ACHE Excellence Award for Leadership and Management recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in leadership and management in leading a hospital or healthcare organization. The 2023 winners of this award are:

Gold:

Matosinhos Local Health Unit (ULSM) (Portugal), Chronic Complex Patients Support Team.

Silver:

Royal Hospital (Oman), Introducing and implementing patient experience in Royal Hospital.

Bronze:

Dubai Health Authority (United Arab Emirates), Process maturity framework.

Honorable mentions:

- Al-Kharj Maternity and Children Hospital (Saudi Arabia), Advancing emergency care accessibility and efficiency: A collaborative approach with the primary health sector to establish an urgent care clinic.
- Emirates Health Services (United Arab Emirates), Electronic autism screening module.
- SEHA Kidney Care (United Arab Emirates), Enhancing organ procurement and transplantation in the UAE.
- Karolinska University Hospital (Sweden), Sterile service transformation at Karolinska.
- Henry Ford Health (United States), Women-inspired neighborhood network: Detroit.

This year, IHF received over 500 entries from more than 40 countries and territories—the highest number of submissions since the awards were established in 2015.

IHF World Hospital Congress Wrap-Up

Healthcare and hospital leaders from around the world flocked to Lisbon, Portugal, in October to attend the 46th World Hospital Congress of the International Hospital Federation, which featured the theme “Global learning, local action.”

“I can think of no better way to describe the purpose and impact this community can provide. To learn from each other, global experts, and bring new ideas back home. Wherever home may be for each of us. The IHF is a global community, comprised of the many relationships we have forged with one another,” said Deborah J. Bowen, FACHE, CAE, IHF immediate past president, in her welcoming address. Bowen is also president and CEO of ACHE.

In a keynote video address, Dr. Tedros Adhanom Ghebreyesus, director-general of the World Health Organization, spoke of the vital role of hospital management in achieving progress toward universal health coverage.

Save the date for the 47th IHF World Hospital Congress, which will be held Sept. 10–12, 2024, in Rio de Janeiro.

20

Happy
New
Year!

2021

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



American College of
Healthcare Executives®

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

Ashley E. Abbondandolo, administrative director, Strategic Growth & Development, Memorial Healthcare System, Hollywood, Fla., received the Early Careerist Healthcare Executive Award from the Regent for Florida—Eastern.

Moses K. Ajayi, CHRISTUS Health, received the ACHE of East Texas Chapter Connector Regent's Award from the Regent for Texas—Northern.

Carlos H. Ayllon, FACHE, director, Operations, Nicklaus Children's Pediatric Specialists, Miami, received the Mid-Careerist Healthcare Executive Award from the Regent for Florida—Eastern.

Daniel T. Bae, director, Cardiovascular Service Line, Overlake Medical Center, Bellevue, Wash., received the Early Careerist Healthcare Executive Award from the Regent for Washington.

Jennifer T. Baker, FACHE, senior director, Clinical Operations,

Intermountain Healthcare, Salt Lake City, received the Early Careerist Healthcare Executive Award from the Regent for Utah.

Michael P. Bartell, FACHE, CEO, Encompass Health Lakeshore Rehabilitation Hospital and Encompass Health Rehabilitation Hospital of Shelby County, Birmingham, Ala., received the Senior-Level Healthcare Executive Award from the Regent for Alabama.

Kate Becker, FACHE, CEO, UNM Hospitals, Albuquerque, N.M., received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Rachel Blasko, vice president, Operations, WVU Medicine Children's, Morgantown, W.Va., received the Early Careerist Healthcare Executive Award from the Regent for West Virginia & Western Virginia.

Crystal V. Brown, vice president, Operations/COO, Methodist

Mansfield (Texas) Medical Center, received the ACHE of North Texas Executive Servant Leader Regent's Award from the Regent for Texas—Northern.

Hoyt J. Burdick, MD, CMO, Mountain Health Network, Huntington, W.Va., received the Senior-Level Healthcare Executive Award from the Regent for West Virginia & Western Virginia.

Alyson Capp, PhD, director, Ethics, Advocate Aurora Health, Downers Grove, Ill., received the Diversity Champion Award from the Regent for Wisconsin.

Amy B. Christensen, RN, FACHE, vice president/CNO, Specialty Based Care, Intermountain Healthcare, Salt Lake City, received the Senior-Level Healthcare Executive Award from the Regent for Utah.

Ashli B. Danilko, FACHE, CEO, St. Michael's Hospital Avera, Tyndall, S.D., received the Senior-Level Healthcare Executive Award from the Regent for South Dakota.

Richelle R. Webb Dixon, FACHE, senior vice president/COO, Froedtert Hospital, Milwaukee, received the Mid-Level Careerist Award from the Regent for Wisconsin.

Stephanie Dorwart, CEO, Altius Healthcare Consulting Group, Arnold, Pa., received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania.

Patricia T. Driscoll, JD, professor, Texas Woman's University—Dallas,

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.

received the ACHE of North Texas Legacy Leader Regent's Award from the Regent for Texas—Northern.

Tim Farley, FACHE, director, Operations, ASCs—South Region, AdventHealth, Altamonte Springs, Fla., received the Mid-Careerist Healthcare Executive Award from the Regent for Florida—Eastern.

Dossy Felts Jr., FACHE, director, Operations, Global Center for Health Security, University of Nebraska Medical Center, Omaha, Neb., received the Career Excellence Award from the Regent for Nebraska & Western Iowa.

Daniel J. Fisher Sr., FACHE, assistant chair, Admin and Operations, University of Pittsburgh, received the Outstanding Service Award from the Regent for Pennsylvania.

Matthew K. Garner, FACHE, CEO, Broward Health North, Deerfield Beach, Fla., received the Senior-Level Healthcare Executive Award from the Regent for Florida—Eastern.

Elizabeth Gerhardt, FACHE, director, Nursing, Holton (Kan.) Community Hospital, received the Early Careerist Healthcare Executive Award from the Regent for Kansas.

Richard G. Greenhill, DHA, FACHE, program director and BSHM/assistant professor, Texas Tech Health Sciences Center, Lubbock, Texas, received the ACHE of North Texas Ambassador for the Progression of Healthcare Delivery Regent's Award from the Regent for Texas—Northern.



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Kreg R. Gruber, FACHE, CEO, Beacon Health System, South Bend, Ind., received the Senior-Level Healthcare Executive Award from the Regent for Indiana.

Juan M. Guzman, COO, Indiana University Health, Indianapolis, received the Early Careerist Healthcare Executive Award from the Regent for Indiana.

Catherine A. Jacobson, president/CEO, Froedtert Health, Milwaukee, received the Senior-Level Healthcare Executive Award from the Regent for Wisconsin.

Morgan H. Kennedy-Lamphier, senior talent technology and design consultant, Orlando (Fla.) Health, received the Early Careerist Healthcare Executive Award from the Regent for Florida—Eastern.

Lenetra King, FACHE, executive leadership coach, Watch Me Excel, Fort Worth, Texas, received the ACHE of North Texas Leadership Leverage Regent's Award from the Regent for Texas—Northern.

James A. Kranz, vice president, Quality and Data Services, WV Hospital Association, Charleston, W.Va., received the Lifetime for Extraordinary Service to ACHE Award from the Regent for West Virginia & Western Virginia.

Sofia Adaime Martinez, FACHE, associate administrator, Hospital Auxilio Mutuo, San Juan, Puerto Rico, received the Early Careerist Healthcare Executive Award from the Regent for Puerto Rico.

Brittany McCreery, MD, FACHE, vice president, Quality, Safety & Value, Fred Hutchinson Cancer Center, Seattle, received the Senior-Level Healthcare Executive Award from the Regent for Washington.

Tiffany McKenzie, manager, Thought Leadership, Health Management Associates, Lansing, Mich., received the Career Excellence Award from the Regent for Pennsylvania.

Seetha Modi, FACHE, community relations director, Texas Health HEB, Bedford, Texas, received the ACHE of North Texas Emerging Leader Regent's Award from the Regent for Texas—Northern.

Melissa R. Moran-Hodge, program manager, Ambulatory Operations and Quality, Proliance Surgeons, Seattle, received the Early Careerist Healthcare Executive Award from the Regent for Washington.

Jesse Naze, CFO, Fall River Health Services, Hot Springs, S.D., received the Healthcare Leadership Award from the Regent for South Dakota.

Tracy D. O'Rourke, FACHE, senior vice president/COO, StormontVail Health, Topeka, Kan., received the Senior-Level Healthcare Executive Award from the Regent for Kansas.

Bradley D. Pfeifer, FACHE, assistant dean, Operations & Management, College of Public Health, University of Nebraska Medical Center, Omaha, Neb.,

received the Outstanding Service Award from the Regent for Nebraska & Western Iowa.

McKenna Raimier, University of Iowa College of Public Health, Iowa City, Iowa, received the Student Award from the Regent for Iowa.

Eric Ransom, FACHE, vice president, Operations, Advocate Aurora Health, Downers Grove, Ill., received the Early Careerist Healthcare Executive Award from the Regent for Wisconsin.

Victor J. Rosenbaum, FACHE, vice president, Ambulatory and Post-Acute Services, Orlando (Fla.) Health, received the Senior-Level Healthcare Executive Award from the Regent for Florida—Eastern.

Eduardo Sotomayor Jr., LFACHE, received the Senior-Level Healthcare Executive Award from the Regent for Puerto Rico.

Tanya A. Stinson, CEO, Leaning Towards Change, Dallas, and supervisor, Data Governance, Texas Health Resources, Arlington, Texas, received the ACHE of North Texas Chapter Connector Regent's Award from the Regent for Texas—Northern.

Jimmy Stout, director, Safety & Quality, Trivent Healthcare, Boca Raton, Fla., received the Clinical Healthcare Executive Leader Award from the Regent for Alabama.

Caitlyn P. Traffanstedt, supply chain business analyst, East Alabama Medical Center, Opelika, Ala., received the Early Careerist Healthcare Executive Award from the Regent for Alabama.

ACHE Policy Statement Updates

In 2023 the ACHE *Code of Ethics* and the following five policy statements were updated to better align with our changing times.

- Employment Agreements for Healthcare Executives
- Evaluating the Performance of the Hospital or Health System CEO
- Healthcare Executives' Role in Mitigating Workplace Violence
- The Healthcare Executives' Role in Fostering Inclusion of LGBTQ+ Patients and Employees
- Lifelong Learning and the Healthcare Executive

Learn more at **ACHE.org**

ACHE's Policy Statements outline the organization's position on important healthcare issues and guide healthcare leaders to best practices.

ACHE.org



Advancing Diversity and Inclusion

Chapters are recognized for their commitment to DEI.

As an ACHE core value, diversity and inclusion is integral to the organization's mission and daily work in creating a more diverse and inclusive healthcare leadership. Chapters are demonstrating their commitment through numerous programs and initiatives.

The Regents-at-Large who represent Districts 1–5 annually recognize a chapter from their region that actively demonstrates a commitment to and successful implementation of significant diversity, equity and inclusion efforts within the chapter, community and healthcare management field.

ACHE Chair Delvecchio S. Finley, FACHE, presented the 2023 Regent-at-Large Award for Chapter Accomplishments in Diversity to the five chapters during the Chapter Leaders Conference in September. He also thanked all of ACHE's 76 chapters for their work fostering engagement in diversity and inclusion. The following chapters received the award.

CT Association of Healthcare Executives

CT Association of Healthcare Executives is a steadfast leader in diversity, equity, inclusion and belonging, and its Diversity

Committee, formed in 2018, regularly reviews and audits data to ensure the chapter offers a welcoming and comforting environment for all. A recent internal survey helped the chapter gain an understanding of the current climate of its DEIB efforts and allowed for leaders to make informed and intentional decisions to further drive the chapter's mission and vision.

Recent initiatives that warrant the award include creating a diversity statement that all board members follow, offering education each year surrounding the topic of DEIB, publishing diversity-focused articles in the chapter's newsletter, ensuring chapter membership is diverse and fostering closer partnerships with partner organizations.

The chapter also encourages the use of pronouns in membership email signatures, and it recently purchased pronoun buttons that were used at a social event. The committee also has made intentional efforts to be inclusive of age, education, socioeconomic status, disability and more. When possible, the chapter ensures all in-person events are accessible to persons with disabilities.

In addition to these accomplishments, CTAHE mentored and

identified two new co-chairs of the Diversity Committee, one of whom has a certification in diversity. Together they have made strategic changes to have a diversity representative on every committee, and they are working with the treasurer to develop a diversity sponsorship program to award one member with the opportunity to attend all chapter-hosted events for free. This effort is expected to help further engage diverse members who may not already receive funding for professional development.

ACHE of Georgia

ACHE of Georgia is firmly committed to driving diversity and inclusion within all aspects of healthcare through empowering, educating and engaging Georgia healthcare executives.

The chapter partners with the Georgia Chapter of the National Association of Health Services Executives to create an innovative approach for embedding DEI in the chapter. Since the beginning of the partnership in 2021, an ACHE of Georgia member holds a permanent position as vice president of the Georgia NAHSE chapter board. This partnership ensures coordination of DEI efforts and demonstrates a commitment beyond joint programs or conversation.

Some of ACHE of Georgia's other efforts include publishing a 2022 resource calendar of diversity and inclusion; publishing Black History Month posts on the chapter's website; holding webinars on racial diversity, diversity in veterans healthcare and health disparities in the state; helping establish a Georgia

National Association of Latino Healthcare Executives chapter; and developing a Diversity Assessment Tool Survey.

Additional events and activities include a virtual focus group centered on diverse members, a webinar on health equity in Georgia and a networking event at NAHSE's national conference in Atlanta that took place in October.

Indiana Healthcare Executives Network

The Indiana Healthcare Executives Network started its journey to enhance DEI awareness and actions in 2019. As the industry normalized under pandemic conditions, the chapter resurrected its efforts by

consulting with ACHE on structure, alignment with activities and goals, and the chapter's demographic data to identify meaningful opportunities.

Recommendations were submitted to the board to modify its bylaws with a commitment to DEI and revalidate its diversity statement. As a result, DEI became a stand-alone committee rather than a subgroup of the Nominations Committee. In 2022, the committee supported and identified panelists for implicit bias programming. The program was well attended, with about 40 participants representing multiple sectors including health systems, education and state government, and the airport authority.

In 2023, the network's DEI efforts gained significant momentum with a number of accomplishments:

- The creation of a podcast focused on DEI.
- The publication of a DEI calendar recognizing key DEI areas each month and promoting awareness via social media.
- Financial support and facilitation with the National Association of Latino Healthcare Executives to back its inaugural launch in Indiana.
- Launching an "allyship" agreement for DEI affinity partners to collaborate on resources, programs and

ACHE IS NOW ACCEPTING SCHOLARSHIP APPLICATIONS

- **Albert W. Dent Graduate Student Scholarship (for racially and/or ethnically and LGBTQ+ diverse students)**
- **Foster G. McGaw Graduate Student Scholarship**

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 29, 2024**.

For more information visit [ACHE.org/Scholarships](https://www.ache.org/Scholarships)

Applicants will be notified in July.

efforts related to DEI (three agreements were completed).

- Deploying the first DEI survey to chapter members to identify opportunities to support programming, awareness and collaboration efforts.

ACHE of North Texas

ACHE of North Texas has worked diligently to ensure it upholds the DEI initiatives of ACHE. The DEI Committee has collaborated with other committees to ensure its membership mix is well represented. The focus has been concentrated on expanding efforts to ensure all people and diversity groups are recognized and included in the chapter's processes. Some of the initiatives the DEI Committee spearheaded include:

- Acknowledging and celebrating diversity-centric holidays. This recognizes diverse groups by celebrating diversity-aimed months of recognition and holidays.
- Celebrating our stories by conducting spotlight stories of diversity from the membership.
- Instituting the Asian Healthcare Leaders Community of North Texas. The goal is to ensure Asian American healthcare leaders are well represented and collaborative within the healthcare community. This translates into better representation and greater voice on healthcare-related matters for Asian American patients.
- Launching the LGBTQ Healthcare Leaders Community. Focused on those interested in promoting the acknowledgement,

discussion of and commitment to successfully resolving issues of the LGBTQ healthcare executives' community, the forum offers an opportunity for leaders to support one another while bringing awareness to these issues. This committee is integral to ongoing promotion of awareness, support, recognition and respect for LGBTQ+ healthcare leaders.

- Holding multiple networking/learning events focused on DEI initiatives. The DEI Committee hosts a plethora of events throughout the year to ensure DEI issues are openly discussed and addressed. The committee also partners with organizations that focus on DEI initiatives for healthcare executives throughout Texas and surrounding states. The DEI Committee for ACHE of North Texas has hosted such events to promote inclusion throughout the year, and these are well attended by numerous organizations.

Arizona Healthcare Executives

Over the past three years, Arizona Healthcare Executives has made great advances in pursuit of DEI with advocacy and encouraging diversity in its leadership and board. This has made a positive impact on the diversity of its committee members and the offerings to its membership. The chapter also hosted a virtual education session titled "Embracing A Dialogue about Gender Identity and Intersectionality" and a virtual session titled "Equity of Care: A Quality and Safety Imperative and a New National Patient Safety Goal," which received

overwhelming positive feedback. And the chapter held a breakfast event titled "Women Leaders and Gender Parity in Healthcare Leadership."

The chapter's DEI Committee completed numerous initiatives over the past year, including authoring "DEI Initiative: An Essential Business," a diversity, equity and inclusion primer (with definitions and examples) that appeared in the chapter newsletter. The committee also submitted to ACHE a proposal for a new education template, "Women Leaders and Gender Parity in Healthcare Leadership," which ACHE accepted for other chapters to use.

The chapter's program development committee is intentional in recruiting diverse panelists and locations for chapter educational offerings. For example, in February 2023, the committee partnered with NAHSE's Arizona chapter to sponsor a workshop and panel event, "Leadership Super Power: Civility & Respect in Healthcare." The event drew the chapter's highest registration and attendance in many years, with a diverse audience engaged in respectful, meaningful dialogue. With the addition of a new chair of the Community Outreach Committee, the chapter has added several community events that serve the diverse population of the state, such as food banks and community gardens. ▲

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

ACHE Members in the News

ACHE Members in the News highlights Members and Fellows who are in the news making a positive impact on the healthcare profession.

News makers and promotions will be highlighted from open news sites. Check back weekly to read about members making news.



[HealthcareExecutive.org/member-news](https://www.healthcareexecutive.org/member-news)

Submit an Item

If you or an ACHE colleague are featured or appear in a news outlet, please provide a link for consideration.

Submit your ACHE Members in the News or On the Move suggestions to he-editor@ache.org.

[HealthcareExecutive.org/member-news](https://www.healthcareexecutive.org/member-news)



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Campbell



Koernig



Libby



Marsh



Ordowich



Prado

Brent Burish to interim CEO, HCA Healthcare West Florida Division, Tampa, Fla. He will continue as CEO of HCA Florida Pasadena Hospital.

Kyle D. Campbell, FACHE, to COO for Enterprise Clinic Operations, WellMed Medical Management Inc., San Antonio, from senior vice president for Enterprise Clinic Integrations.

Michael J. Charlton to president/CEO, AtlantiCare Health System, Egg Harbor Township, N.J., from interim president/CEO.

George Gilliam, DPT, FACHE, from director, Rehabilitative Services, HCA Florida Kendall Hospital, Miami, to vice president, Operations, HCA Florida Northwest Hospital, Margate, Fla.

Felissa Koernig, JD, FACHE, to president/CEO, Oneida (N.Y.) Health from president, Guthrie Corning (N.Y.) Hospital.

Cynthia Libby to president, Providence Alaska Foundation, Anchorage, Alaska, and chief philanthropy officer, Providence Health & Services, from region director of operations, Providence Alaska Foundation.

Ernesto Lopez, FACHE, to president, Denver Hospice, from president/CEO, Hospice of Washington County, Hagerstown, Md.

Wes Marsh, FACHE, to administrator, Department of Neurosurgery, University of Florida Health, Jacksonville, Fla., from operations manager, Department of Neurosurgery.

Kathryn McLaughlin, DrNP, NEA-BC, NE-BC, to COO, Hemet (Calif.) Global Medical Center and Menifee (Calif.) Global Medical Center, from CNO, Memorial Hospital of Gardena (Calif.).

Rand O'Leary, FACHE, to president, Henry Ford Wyandotte (Mich.) Hospital, from senior vice president, Northern Light Health, Brewer, Maine, and president, Northern Light Eastern Maine Medical Center.

Marcie Ordowich, FACHE, to COO, RWJBarnabas Health Medical Group, West Orange, N.J., from vice president, Service Line Operations, Penn Medicine, University of Pennsylvania Health System, Philadelphia.

Luis M. Prado, MD, FACHE, to National CMO, St. John of God HealthCare, Australia, from CMO, Epworth Healthcare, Melbourne, Victoria, Australia.

Annette Seabrook, FACHE, to president, Orlando (Fla.) Health's freestanding inpatient rehabilitation institute, from market CEO, LifePoint Health, Brentwood, Tenn.

Want to submit?

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

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1-602-369-7656

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7613 E Ray Road

Suite 101

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