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WORKFORCE WELLNESS
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Cover Story

**The Secret to Safer Patients: Workforce Wellness**

Healthcare workers may seem superhuman to many, but they at times get tired, unhappy and anxious—just like everyone else. As a result, patient safety and quality of care may suffer. Though a challenge, once solved, the problem provides an opportunity.

Features

**Anthony A. Armada, FACHE: A Profile of ACHE’s 2022–2023 Chair**

Anthony A. Armada, FACHE, will assume office as Chair of ACHE on March 26. He is executive vice president/chief transformation officer, Generations Healthcare Network, Lincolnwood, Ill.

**Health Equity as a Patient Safety Imperative**

Care that is not equitable can impact patient safety, and it is imperative that health equity become a strategic priority for leadership.

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Research has demonstrated that when the workforce is engaged, staff become more productive, which can translate into improved quality and safety outcomes. And, to further strengthen patient safety, equitable care is needed.

In our cover story “The Secret to Safer Patients: Workforce Wellness” (Page 16), we delve into how leaders can facilitate excellent patient care by prioritizing employee well-being. Experts stress there is a strong correlation between quality of care and work conditions. They say medical errors are associated primarily with organizational climate and office environment. Specifically, burned out and dissatisfied physicians are more likely to make errors and deliver suboptimal patient care.

However, work conditions, organizational climate and office environment are not immutable, and leaders can improve them. All it takes is a commitment to systemic change—and creative ideas with which to make it happen.

In our feature “Health Equity as a Patient Safety Imperative” (Page 24), we see how inequitable care can impact patient safety. To attain health equity within their patient populations, it is imperative that it become a strategic priority for leadership.

Finally, in the feature “Anthony A. Armada, FACHE: A Profile of ACHE’s 2022–2023 Chair” (Page 10), we introduce Armada, executive vice president and chief transformation officer, Generations Healthcare Network, Lincolnwood, Ill. Armada, who will assume office as Chair of ACHE at the Council of Regents Meeting March 26, shares his professional experiences and plans for ACHE.

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

Balancing short- and long-term strategies to solve complex issues.

Deborah J. Bowen, FACHE, CAE

Workforce. Workforce. Workforce. No topic has occupied our hearts and minds so deeply as those who do the important work of caring for patients. Labor shortages have led recent headlines, and embedded in the stories are the details of personal loss, grief and countless demonstrations of courage, perseverance and empathy.

Illustrating the challenge is the data from ACHE’s 2021 Top Issues Confronting Hospitals survey, where hospital CEOs have ranked personnel shortages as their No. 1 concern—the first time since 2004 that financial challenges has not held the top spot. When looking at the survey results on Page 62, readers will more clearly understand that shortages and financial challenges go hand in hand as labor costs rise and solutions seem elusive.

Though the healthcare labor shortage is not a new topic, the signals are more urgent as the list continues to expand across the care continuum to include roles like therapists and lab and medical technicians. Both short-term and long-term solutions will be needed if we are to find ways to support our essential workforce partners, while also facing the financial realities before us. A few thoughts may serve as starting points.

Build organizational well-being. The immediate priority is relieving physical and psychological stress for the front line. Though strong tactics like zero tolerance policies must be in place to protect workers, strategies must go further. Prioritizing well-being resources, allowing time and space to rest and finding ways to bring joy into our work will help create a safe, resilient culture.

Evidence suggests professional development can make a difference as well. Supporting and investing in continuing education both ensures up-to-date clinical skill sets and improves professional well-being through expanded opportunities to learn and grow. Clinical practitioners also report that both face-to-face and virtual development opportunities impact their decisions to stay with their organizations. Mentors, sponsors and coaches can also add to a learning environment that helps advance clinicians and, ultimately, the patients they serve.

Solve for tomorrow, today. Overall, workforce must be central to strategic planning to ensure structure, resources and investments thoughtfully address and fund relevant priorities. Some organization are hiring chief wellness officers, creating well-being champions and experimenting with other new initiatives. Some are partnering with educational institutions and community organizations to increase the recruitment pool—cultivating a diverse mix of future talent. Regardless of approach, incorporating long-term solutions today is necessary to create a foundation for future success.

People are our most precious resource. While we may not solve for shortages overnight, leadership is uniquely positioned to find innovative care delivery solutions, identify and grow talent, improve well-being, and reduce the burden on our workforce. Let us all rise to the challenge of doing more.

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

Editor note: For more resources, consult the American Hospital Association’s 2022 Healthcare Talent Scan at aha.org/aha-talent-scan.
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Healthcare is a reflection of the communities we serve, and 2021 was a roller-coaster year for everyone. But the disruptions we all faced at home and work over the past 12 months highlighted the importance, the fortitude and the perseverance of our front-line caregivers and everyone who supports them. Many of the challenges we faced were new and required strong and resilient leadership.

When I assumed the role of ACHE’s Chair at this time last year, it was serendipitous my journey with Kaiser Permanente was also beginning. As the new Northern California president, I was learning the organization and its culture, while also working to support a team facing some of the most challenging times in their careers, both personally and professionally. At the same time, I was focusing on the future and how we could elevate virtual care to best meet the needs of patients.

All of ACHE’s members—and the organization itself—were on a similar journey. This required ACHE leadership to think about how ACHE could transform itself to not only meet the rapid changes happening in the world, but also anticipate how it needed to evolve over the next three years to continue to be a valuable resource and professional home for its membership.

Vital to our rethinking has been listening to our members and understanding not only what people are going through professionally but also how they are faring as individuals. What we heard members tell us is they didn’t feel comfortable coming to events in person, so ACHE’s amazing, talented team shifted to an all-virtual Congress on Healthcare Leadership, which had 9,200 attendees—more than double the normal conference registration. The turnout highlighted the incredible appetite for education and shared experiences. In addition to taking Congress online, ACHE made sure critical education opportunities were at the fingertips of members and nonmembers through podcasts and multiple, free online sessions.

One of the most wonderful things about Congress has always been seeing colleagues in person and the hallway conversations, where billion-dollar deals and lifelong friendships are made. Though during the virtual event we didn’t share the hallways in a physical sense, a feeling of belonging still flourished through a chat feature, where people could say hello from around the world and had the opportunity for online social networking.

I’m proud of how the shift toward an online presence has helped continue to make ACHE the professional home for so many—connecting you to the greater community and giving you a sense of belonging to your profession. I’m also delighted by how ACHE has led in providing critical education and sharing of best practices and lessons learned from leaders across the country and around the globe over the past year.

The pandemic gave us a unique opportunity to reflect and challenge the traditional norms that are no longer serving us and, as we look to the future, determine what we need to do differently to continue to meet our members’ needs. I am excited about ACHE’s work toward diversity, equity and inclusion. We held 10 DEI sessions at Congress last year, with over 10,000 session participants. Our Executive Diversity Career Navigator has had nearly 30,000 page views to date, local chapters have held 61 DEI virtual programs in 2021, and our LGBTQ and Asian Healthcare Leaders Communities have grown to 351 and 405 members, respectively.

In addition, the Thomas C. Dolan Executive Diversity Program expanded from six to 11 scholars per year, and we have awarded three unique scholarships, totaling over $700,000 given to 140 recipients since 2014.

I’m confident that with our collective focus, we can continue to evolve how we support our membership and the value of ACHE. No doubt, we’ve always known the value of working together, but the pandemic and lessons from the past year have reinforced the importance of our strength in numbers.

Carrie Owen Plietz, FACHE, is regional president, Kaiser Permanente Northern California, Oakland, and on March 26 becomes the 2022–2023 Immediate Past Chair of ACHE.
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Having grown up in a family of caregivers, Anthony A. Armada, FACHE, who goes by Tony, was destined for a career in healthcare. Following the lead of his parents and five siblings—all of whom work as clinicians—Armada began his career working the midnight shift in a laboratory as a medical technologist. However, he soon discovered that his passion was in healthcare management. He liked interacting with people and working with teams, and he appreciated working in an environment that fostered continual learning. Armada realized that as a leader, he could motivate people to perform at their best.

During his 40-year career, he has done just that, leading numerous organizations at the chief executive level, including Providence Saint Joseph Health, Advocate Health Care, Henry Ford Health System and Kaiser Permanente. Since August 2021, he has held the role of executive vice president and chief transformation officer with Generations Healthcare Network, a senior care management and consulting firm in Lincolnwood, Ill.

And, on March 26, Armada will add a new chapter to his prolific career as a leader when he assumes office as Chair of the American College of Healthcare Executives.

**A Servant Leader**

During his years of healthcare leadership, Armada has gained extensive experience in integrated delivery models, developing leaders and championing culture change. He has spearheaded hospital turnarounds and growth and developed a keen understanding of how to deliver safe, high-quality care along the continuum, and of the collaboration needed in accountable care models. He knows the importance of patient experience, employee and physician engagement, improving access to care, achieving financial goals, and establishing relationships within the community.
Tony has brought to Generations Healthcare Network a new way of thinking. With his ‘five-best approach,’ he has taught our staff that our day-to-day operation has to have a ‘why’ and ‘how’ with meaningfulness and purpose,” says Bryan G. Barrish, principal and a managing member of Generations Healthcare Network.

The five-best approach is a way for leaders to ensure patients are provided with the best in safety, quality, health outcome and experience, and staff are provided with the best place to work and practice and the best use of resources. “This approach has focused our energies on quicker solutions and to overcome obstacles in a focused and efficient fashion,” Barrish adds.

Along with the expertise he’s gained, Armada has collected other valuable lessons along the way. As an early careerist, he realized that relationships are vital to the profession of healthcare leadership. During these years, he focused on learning and experiencing as much as he could from the guidance provided by mentors such as Richard D. Cordova, FACHE, president emeritus of Children’s Hospital Los Angeles and a Past Chair of ACHE.

“Trustworthy,” “loyal,” “passionate,” “authentic” and “servant leader” are words Cordova uses to describe Armada, whom he met when Armada was interviewing for a service area manager vice president position with Kaiser Permanente.

“Servant leader is a description that people often use, but with Tony, he lives it. Everywhere he goes, he gains loyalty from his team and is the type of nurturing leader that develops his people so they thrive in the organizations he’s led,” Cordova says of Armada, whom he ended up hiring and mentoring before the two became friends.

One example of the loyalty Armada has garnered as a leader comes from physician leader Wayne M. Goldstein, MD, professor of clinical orthopedics at the University of Illinois at Chicago; chair of the Department of Orthopedic Surgery at Advocate Aurora Lutheran General Hospital, Park Ridge, Ill.; and president and founder of the Illinois Bone and Joint Institute. He first met Armada, who had recently become president of Advocate Lutheran General Hospital and Children’s Hospital, when Armada asked Goldstein to meet for breakfast. Goldstein had left Advocate Lutheran General Hospital for another hospital before Armada joined the organization, and Armada wanted to learn why.

Upon hearing his reasons for leaving, Armada asked Goldstein if he would consider returning to Advocate if Armada could have 10 months to address his concerns. Not only did Armada deliver on his promises, which included the creation of a separate department of orthopedics with private rooms for patients and more time for surgeons in the OR, he also brought people together, according to Goldstein.

“Even though Lutheran General was huge, Tony brought a sense of togetherness, and people liked to go to work instead of dreading it,” Goldstein says, sharing how he once saw Armada sitting by the loading dock of the hospital, chatting with the custodial staff. “I would say that he has been the most transformative leader I ever saw in my life.”

Just as Armada won over the admiration of staff at Advocate, he also left a favorable impression on colleagues at Swedish Health Services.

“What you see is what you get with Tony,” says William “Bill” W. Krippaehne Jr., a former board member at Swedish who worked with Armada when he was CEO there. “I think one of the most important things that you get with Tony is the foundation of values that his actions are built on, the cornerstone of which is personal integrity,
and then quickly surrounded by things like respect for others, inclusiveness, an inquisitive mindset, and a willingness to be wrong and listen to others. I think that’s a pretty remarkable person,” Krippaehne says.

As he progressed in his career, Armada continued to gain new insights and perspectives from others while also coaching and mentoring younger professionals. He relishes the opportunity to see colleagues reach their potential. “When you start seeing people you worked with as directors who are now CEOs, that to me is the most rewarding experience,” he says.

In addition to the pride he derives from watching those he’s mentored and coached succeed, Armada prizes the work he has accomplished in the area of diversity, equity and inclusion.

He has served on the Equity of Care Committee sponsored by the American Hospital Association and is a past chair of the board of AHA’s Institute for Diversity and Health Equity. Additionally, he was the inaugural chair of ACHE’s Asian Healthcare Leaders Association board, now known as the Asian Healthcare Leaders Community. He has been named three times as one of

### WORK HISTORY

#### 2021–Present
Executive Vice President/Chief Transformation Officer

#### 2020–2021
AHMC Health System, Alhambra, Calif.
President/CEO, Seton Medical Center, Daly City, Calif., and Seton Medical Center Coastside, Moss Beach, Calif.

#### 2018–2020
Verity Health System, Los Angeles System CIO

#### 2017–2018
Strategy Advantage, Los Angeles X-CO Expert Partner

#### 2017–2018
AA Armada Associates, Seattle Managing Partner/CEO

#### 2013–2017
Providence Saint Joseph Health, Renton, Wash.
Executive Vice President/CEO, PSJH—Western Washington Market (2015–2017)
Senior Vice President/CEO (System), Swedish Health Services (2013–2015)

#### 2009–2013
Advocate Health Care, Park Ridge, Ill.
President, Advocate Lutheran General Hospital and Children’s Hospital

#### 2004–2009
Henry Ford Health System, Detroit
President/CEO, Henry Ford Hospital and Health Network

#### ACHE HISTORY
Chair, 2022–2023
Chair-Elect, 2021–2022
Governor, 2017–2020
ACHE Regent-at-Large for District 3, 2013

#### EDUCATION
MBA and MHA, Xavier University, Cincinnati
BS, Michigan State University, East Lansing, Mich.

#### CURRENT AFFILIATIONS
Member, Healthcare Executive Study Society
Member, Standards Council, Commission on Accreditation of Healthcare Management Education
Member, Beaumont Society, Michigan State University
Member, Alumni Association, Xavier University

2000–2004
Kaiser Permanente, Los Angeles
Senior Vice President/Area Manager, Kaiser Foundation Health Plan and Hospitals

1998–2000
Catholic Healthcare West, Northridge, Calif.
Senior Vice President/COO, Northridge Hospital Medical Centers

1995–1998
Columbia Chino (Calif.) Valley Medical Center
President/CEO

1991–1995
Torrance (Calif.) Memorial Medical Center
Vice President

1990–1991
Coastal Communities Hospital, Republic Health Care, Santa Ana, Calif.
CIO

1988–1990
Charter Suburban Hospital, Paramount, Calif., and Charter Oak Hospital, West Covina, Calif.
Assistant Administrator

1987–1988
Saint Joseph Hospital, Elgin, III.
Assistant Resident

1982–1985
Saint Lawrence Hospital, Lansing, Mich.
Medical Technologist

2000–2004
Kaiser Permanente, Los Angeles
Senior Vice President/Area Manager, Kaiser Foundation Health Plan and Hospitals

1998–2000
Catholic Healthcare West, Northridge, Calif.
Senior Vice President/COO, Northridge Hospital Medical Centers

1995–1998
Columbia Chino (Calif.) Valley Medical Center
President/CEO

1991–1995
Torrance (Calif.) Memorial Medical Center
Vice President

1990–1991
Coastal Communities Hospital, Republic Health Care, Santa Ana, Calif.
CIO

1988–1990
Charter Suburban Hospital, Paramount, Calif., and Charter Oak Hospital, West Covina, Calif.
Assistant Administrator

1987–1988
Saint Joseph Hospital, Elgin, Ill.
Assistant Resident

1982–1985
Saint Lawrence Hospital, Lansing, Mich.
Medical Technologist

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A Profile of ACHE’s 2022–2023 Chair

In addition to the pride he derives from watching those he’s mentored and coached succeed, Armada prizes the work he has accomplished in the area of diversity, equity and inclusion.

the “Top 25 Minority Executives in Healthcare” by Modern Healthcare and received the ACHE Dean Conley Award in 2011 for an article he co-authored in Frontiers of Health Services Management, “Diversity in Healthcare: Time to Get REAL!”

ACHE: “A Constant in My Life”
Along with the mentors and coaches who have helped shape Armada into the leader he is today, he also credits ACHE with being a constant in his professional life.

“Whether it’s continual learning through the many educational offerings, getting up to speed on topics of importance in healthcare management, or attaining board certification as a Fellow of ACHE—those experiences are the fabric of who I am as a professional,” says Armada, who joined as a Member in 1991.

He is grateful to ACHE for the opportunity to lead the organization and be involved in developing policies and programs that enable ACHE “to be on the cutting edge of preparing future healthcare professionals.”

He anticipates the greatest challenges future healthcare leaders will face are the different disruptive innovations and paradigms entering the field, as these will change how the healthcare workforce operates. To face these challenges, Armada believes healthcare leaders will need resilience and nimbleness—two attributes executives have had to cultivate to navigate the pandemic. And, he believes ACHE is poised to help leaders develop those skills because of its ability to evolve and meet its members’ needs, no matter what challenges the field is facing. For example, ACHE has been providing virtual education options since the pandemic to ensure members can still earn ACHE Face-to-Face Education credits.

“Anybody I talked to who attended the virtual ACHE Congress on Healthcare Leadership last year was totally blown away, not only by the content but by the delivery and the emphasis on getting the right people as faculty to share their knowledge,” he says.

Leading ACHE to a New Level
As Chair of ACHE, Armada is excited about the dialogue taking place relative to diversity, equity and inclusion.

“Given the continued relevance of learnings during the COVID-19 pandemic, especially the heightened understanding of diversity, inclusion and health equity, I’m committed to taking our diversity and inclusion platform to another level, preparing leaders for the future,” Armada says.

“Tony has never backed away from a challenge,” says Charles “Chuck” D. Stokes, FACHE, executive in residence at the University of Alabama at Birmingham, former president and CEO of Memorial Hermann Health System in Houston, and a Past Chair of ACHE. “He has taken on numerous challenging jobs and situations in his career. This is due to his natural curiosity and his desire to make a difference in the lives of others. His leadership position on the ACHE Board of Governors fits his commitment to lifelong learning and to ensure that ACHE continues to offer world-class learning experiences.”

Reflecting on how grateful he is to ACHE as an organization and to the leaders he’s learned from or served with, Armada says it’s all about giving back to the field.

“As Chair, I hope to instill that on our Board and to continue to provide the mainstay of our vision, to be the preeminent professional society for leaders dedicated to advancing health,” he says. “It really is an honor and privilege to serve in a leadership role in an organization that has been a constant in my life.”

Lea E. Radick is a writer with Healthcare Executive.

Lea E. Radick is a writer with Healthcare Executive.
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Google

Wright L. Lassiter III
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Henry Ford Health System
In action movies and comic books, heroes are superhuman. They’re bigger, faster and stronger than the rest of us. In hospitals, however, heroes are just plain human. While for many in healthcare their work is a vocation, a calling, they at times get tired, unhappy and anxious—just like everyone else. As a result, patient safety and quality of care may suffer.

That can be a challenge. But a challenge, once solved, that provides an opportunity.

Consider the landmark *Minimizing Error, Maximizing Outcome* study. Funded by the Agency for Healthcare Research and Quality from 2002 until 2006, it investigated the effect of physician work conditions on patient care. Encompassing more than 400 primary care physicians and nearly 2,000 patients, it found that more than half of doctors felt stressed out at work, and that more than a quarter were experiencing symptoms of burnout. What’s more, it determined that stressed, burned out and dissatisfied physicians are more likely to make errors and deliver suboptimal patient care.

“It’s a huge issue,” says Mary Beth Kingston, PhD, RN, FAAN, CNO at Advocate Aurora Health, Milwaukee. “When someone is emotionally and physically exhausted, they’re not as engaged in the workplace. And when you’re not as engaged, you’re not as productive. That affects the workforce, but it also affects the patient. That’s where the rubber meets the road. If we don’t have care providers who are engaged in their work, it impacts quality and safety outcomes.”

That’s the challenge. Here’s the opportunity: *Minimizing Error, Maximizing Outcome* found a strong correlation between quality of care and work conditions, and concluded that stress and
medical errors are associated primarily with organizational climate and office environment. Because work conditions, organizational climate and office environment are not immutable, leaders can improve them. All it takes is a commitment to systemic change—and creative ideas with which to make it happen.

Burnout: A Growing Problem
It’s been more than a decade since researchers published the results of the Minimizing Error, Maximizing Outcome study. But because of COVID-19, stress and burnout among healthcare workers is more relevant than ever. In May 2021, for example, researchers from the American Medical Association and Hennepin Healthcare, Minneapolis, published a national survey of more than 20,000 physicians and other healthcare workers, half (49%) of whom said they suffered from burnout. Another 43% were experiencing “work overload,” and 38% reported anxiety or depression.

A 2021 survey by The Washington Post and the Kaiser Family Foundation found similar results: Out of approximately 1,300 frontline healthcare workers, 55% said they felt burned out and 49% said they felt anxious.

“Our healthcare workforce across the nation is in a state of crisis,” says Sarah Arnett, DNP, RN, NEA-BC, vice president of patient care services and chief nurse executive at TidalHealth, a health system serving Maryland’s and Delaware’s Delmarva Peninsula. “Our teams are overwhelmingly fatigued and have grown weary facing the lingering effects of the pandemic.”

But the coronavirus alone is not to blame, Kingston says. “We’ve been talking about burnout in nursing
Since at least the 1980s,” she says. “It’s not new, but the pandemic has exacer-
bated it and shined a big light on it.”

In the brightness of that light, one can see myriad causes of chronic healthcare worker burnout. But if you ask physician and leadership consult-
tant Harjot Singh, MD, and an ACHE Member, they all boil down to just one thing: what famed burn-
out researcher Christina Maslach calls “person-job mismatch.”

“Person-job mismatch is at the very root of burnout,” explains Singh, chief of telemedicine services at Kings View Behavioral Health in Fresno, Calif., who says Maslach puts most person-job mismatches into one of six categories, the first of which is work overload. “Work overload is when the job demands exceed human limits.”

Causes of work overload in healthcare include time constraints; alert or alarm fatigue; new and hard-to-use technology, including EHRs; and cognitive strain, which, according to the AMA, directly or indirectly causes 87.1% of medical errors—even though most safety interventions focus on training clinicians, whose knowledge and skill is responsible for only 12.8% of medical errors.

After work overload, other categories of person-job mismatch are:

• Lack of control, which describes the feeling of being microman-
aged, lacking influence and hav-
ing accountability without
power.
• Insufficient reward, which
describes a lack of pay, acknowl-
edgement or satisfaction.
• Breakdown of community, which
describes employees who feel iso-
lated, antagonized or
disrespected.
• Absence of fairness, which
describes discrimination or favor-
itism in the workplace.
• Values that conflict, which
describes employees who feel like their personal values are under-
mined by their organization.

“These are the six things that cause employees to start losing engagement in the workplace, and what you do about them is how you’re going to be tested as a leader,” Singh says.

Healthy Employees
If person-job mismatch is the root of employee burnout, then leaders must nourish people while also reforming their jobs.

The former is a good place to start, according to Bita Kash, PhD, FACHE, director of the Center for Outcomes Research at Houston Methodist Research Institute and professor of health policy and man-
agement at Texas A&M University. At Houston Methodist, she says, leaders use mindfulness training to promote employee wellness.

One tool recently implemented is an app called It’s All Good Here. More than 13,000 employees—over half the hospital’s workforce—have registered to use, wherein users complete evi-
dence-based exercises that are designed to build gratitude, optimism and resil-
ience, according to Kash. “Research in neuroscience and psychology has confirmed that it’s possible to train the brain to be more positive,” she says. “Setting aside two minutes a day for mindfulness practices does that. It has a long-term effect on your brain and helps you put things in

“When someone is emotionally and physically exhausted, they’re not as engaged in the workplace. And when you’re not as engaged, you’re not as productive.”

Mary Beth Kingston, PhD, RN, FAAN, Advocate Aurora Health

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Mindfulness also is an objective at St. James Parish Hospital, Lutcher, La. There, CEO Mary Ellen Pratt, FACHE, is planning mindfulness training to help stressed-out staff members cope with the rigors of their profession.

“We have to be more proactive about giving ourselves time and space when we need it, about being grateful and about bringing positivity to our work,” Pratt says. “There are techniques to help us do that that can be taught. I want to teach them first to my leadership team and then to my front-line team members to help them be better at managing stress.”

In the meantime, successes, such as good patient outcomes, are highlighted to create positivity. “If you have a patient who’s discharged after 20 days, that’s a huge success story,” Pratt says. “We make a big deal about those kinds of things because it gives meaning to our work.”

Advocate Aurora Health is similarly celebratory. Stories of staff members making a difference are shared in the organization’s newsletter and at the beginning of meetings as a way to stay connected to each other and to their purpose.

“It’s a great way to communicate and share some of the unbelievable things that our people have been doing,” Kingston says.

Another great way the organization helps employees feel connected to their purpose is through formal recognition. Advocate Aurora Health, for instance, has an annual Nursing Excellence Awards program. “We have 22,000 nurses, and this year, we had more than 700 nominations,” says Kingston, who sent a letter of thanks to each of the nominated nurses with a copy of their nomination. “I got so many responses from nurses telling me how meaningful it was, and that it was so wonderful to be nominated by their peers. Never underestimate the importance of that type of recognition.”

But wellness isn’t just about making people feel good. It’s about making them feel centered and supported. To that end, Advocate Aurora Health is upgrading outdated break rooms and creating “zen dens” with comfortable seating and relaxing music.

“It’s important to have quiet areas where people can take breaks during work,” explains Kingston, who says yet another effective tool is a peer-support program. “Providers, nurses and others say their biggest source of support is their co-workers and their immediate leader. So we identify individuals throughout the organization who receive additional training and are identified as peer-support folks. If a team member seems stressed or needs someone to talk to, they are there to help them navigate the many resources we have available.”

Instead of peers, TidalHealth has delegated emotional support to pastoral care workers who are integral in supporting staff and recognizing individuals and teams that are experiencing moral distress, compassion fatigue or are in need of the opportunity to share how they are feeling, according to Arnett, an ACHE Member.

“Providing brief but needed reprieves, our pastoral care team visits all areas with a ‘tea for the soul cart’ and hosts a three-day-a-week virtual spiritual ‘refill’ huddle,” she says.

Healthy Systems
If wellness is the destination, healthy employees will only get organizations halfway there, according to Kingston. To complete the journey, leaders can commit themselves to healthy work environments.

“When we talk about team member wellness in healthcare, many times the
focus tends to be on resilience, which is great. But we have to be very careful not to put all of the accountability on the individual,” Kingston explains. “You’ve got to address the system issues along with individual health.”

Echoes Singh, “It’s very seductive to blame the person [for burnout], but you also have to look at the job itself.” Take alarm fatigue, for example. Doctors and nurses often have a hard time focusing because they’re overwhelmed by beeps and buzzes in the
workplace. One solution, according to Kingston, is centralized telemetry, whereby dedicated staff monitor alerts and use tools so clinicians receive the most pertinent and critical notifications. Increasingly, artificial intelligence can triage alerts, such as lab results, in a similar manner.

Another source of alarm fatigue is when EHRs send alerts to providers and nurses about test results, medications and more. “Having a process to look at alerts—to decide which ones are really actionable and which ones are just noise that we can take away—is really important,” says Kingston, who recommends reviewing all clinical and administrative workflows in a similar fashion. “It’s about deciding what tasks are critical to do and prioritizing those.”

The same questions apply to documentation. TidalHealth’s Arnett suggests collaborating with nursing/clinical informatics leads and frontline staff to charter project evaluating documentation and asking: “What are must-haves, what are nice-tos-haves and what is being collected with no value-added actions?”

Houston Methodist goes so far as to employ human factors engineers to redesign workflows in ways that make clinicians more efficient and effective. “One of the big transformations we’ve implemented to help with workflow is our virtual ICU,” reports Kash, who says it debuted in 2020 at the dawn of the COVID-19 pandemic and helped facilitate safe remote family visitations. A remote monitoring center that captures real-time physiological data, the virtual ICU uses predictive analytics tools to rapidly identify critical risk factors and anticipate patient decompensation. It’s staffed by intensivists and critical care nurses who initiate early interventions and offer additional support to bedside ICU teams.

That’s one example of how technology can lighten healthcare workers’ load. There are many others, according to Arnett, who says TidalHealth has turned to time-saving solutions like single sign-on tools, which allow employees to access multiple systems with a single username and password. “Implementation has saved our staff several minutes each shift in login typing time as well as removed the need to remember multiple passwords for different applications,” she says.

The Healthcare Information and Management Systems Society recommends digital health tools like online diagnostics and symptom checkers, which use automated bots to monitor symptoms and triage patients; virtual nurses, which can prevent readmission by keeping providers connected to patients between visits; professional workflow technologies, which can improve workflows with features like voice-recognition and automated data entry; and workforce management platforms, which use artificial intelligence to automatically generate schedules and identify gaps in shift work.

“Technology can reduce cognitive and administrative burden and limit the number of manual steps needed to execute a task,” Arnett continues.

Of course, technology also can increase cognitive burden. A 2019 study by the Mayo Clinic, for example, found that EHR usability—the extent to which a product can be used … to achieve specified goals with effectiveness, efficiency and

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Sarah Arnett, DNP, RN, NEA-BC, TidalHealth
satisfaction”—is strongly associated with physician burnout.

The key, then, is making technology serviceable. When it recently implemented a new information management system, for example, St. James Parish Hospital deployed it with “shoulder-to-shoulder” support. “We designated super users who worked side-by-side with staff as we went live to help them learn the system, and that worked really well,” notes Pratt, who says leaders must be patient with new technology to realize its benefits. “It can be a burden while you’re still learning it, but it will make it much easier to share information. And that will create a better work environment for our caregivers.”

Often, what employees need more than additional information is additional hands. Therefore, alongside new technology, Pratt has prioritized new staff. Due to a talent shortage in her region, she’s had to get creative. To help overworked nurses, for example, she’s brought in support from advanced practice nurses and physicians, including remote practitioners who are available 24/7 to provide counsel and answer questions. She’s also trying to leverage complementary skills in new ways—for instance, recruiting radiology staff to help with IVs, asking pharmacy techs to help with passing meds or hiring EMTs to do triage in the ED.

And then there’s recruiting. Although it does little to help in the short term, being proactive can help leaders fight burnout in the long term. “We don’t sit back and wait. We cultivate relationships with people before they even finish school,” says Pratt, whose favorite tactic is networking with local moms who can engage their children on her behalf, persuading young doctors and nurses to return home when they graduate. “People are so tired. They need time off, and we need more people so we can give them that relief.”

Winning at Wellness

Whether they target individuals or systems, wellness initiatives can succeed only if they’re inclusive and transparent, according to Kingston, who emphasizes the need for shared governance and psychological safety. The former can be achieved through grassroots feedback loops, while the latter requires a culture of open communication.

“All employees want to have their voices heard, and they want to feel comfortable speaking out without fear of payback or retribution,” Kingston says. “You need top-down communication, but also bottom-up.”

Also, organizations need metrics and measurement to prove the positive impacts of their efforts—not only on providers but also on patients. Although it’s too early to know whether pandemic-era initiatives have contributed to positive patient outcomes, smart organizations are creating mechanisms with which to track those outcomes in the months and years ahead.

“Research and evidence-based practice are really important to determine what actually works,” continues Kingston, whose organization prioritizes safety and quality measures like mortality rates and has embraced real-time patient surveys like the ones retailers often give consumers at the checkout counter. “We’re getting a lot more data about the patient experience, and we’ve started looking at it through an equity lens to see, for example, if there’s a difference in communities of color in terms of patient outcomes and experience.”

Finally, just as important as evidence is buy-in. “You have to be willing to make [wellness] one of your top three strategic initiatives. If it’s not in the top three, nobody’s going to care,” argues Singh, who says organizations that prioritize workforce wellness show their commitment with meaningful funding for wellness programming: executive-level leadership in the form of a chief wellness officer, a CMO and a CNO; and key performance indicators with which to establish benchmarks and measure progress. “Whatever you’re doing to address burnout or engagement, you need to measure it.”

When organizations do, the benefits of workforce wellness will become clear—to their organization, their employees and, most importantly, their patients.

Concludes Arnett, “Team members who are [healthy and engaged] are more likely to deliver consistently compassionate care, connect their work with the organization’s mission, and feel a sense of fulfillment and joy when they are working. The connection with the importance and meaning of one’s work is so important, and the patient’s experience is greatly improved.”

Matt Alderton is a freelance writer based in Chicago.
HEALTH EQUITY
AS A PATIENT
SAFETY IMPERATIVE

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Equal means treating everyone the same. Equitable is providing care services in a way that addresses the patient’s individual needs, which are based on demographic factors, such as age, gender, race and ethnicity, and socioeconomic factors, such as housing, food security, income and education levels.

Care that is not equitable can impact patient safety, as has been clearly demonstrated by the COVID-19 pandemic, which has disproportionately affected marginalized populations, who generally have poorer health and are more vulnerable to disease than nonmarginalized populations.

“Minorities are harder hit from a morbidity and a mortality perspective,” says Marcus Schabacker, president and CEO of ECRI, Philadelphia, a nonprofit organization that focuses on improving safety in healthcare organizations. “They get sick more often, get sicker and they die more often. [COVID-19] just highlighted the issue, which is pervasive throughout healthcare.”

Health Equity as a Strategic Priority
Health inequities begin with the people and organizations that provide care services.

“A healthcare provider’s perceptions, beliefs, attitudes, behaviors and biases have a major effect on patient safety and can determine if that patient receives equitable healthcare or not,” says Trina Parks, FACHE, executive vice president/corporate chief diversity and inclusion officer for RWJBarnabas Health, New Brunswick, N.J.

Parks notes that people of color have worse outcomes compared with the white population across every age and income level, experience significant disadvantages in education and life expectancy, and have higher rates of chronic disease such as cancer, heart disease and diabetes.

It has become clear in healthcare that providing care equally and equitably is not the same.
To attain health equity within their patient populations, it is imperative that health equity become a strategic priority for leadership. A key question to answer: Is patient safety addressed through the lens of equitable care for different patient populations?

“As leaders in healthcare, it is our responsibility to take definitive action to eliminate systemic racism by examining practices and policies within our institutions that manifest discrimination,” says Parks. “First, we must recognize that inequity is prevalent in healthcare and manifests in various settings, including clinical interactions, workforce optimization and community engagement.”

Identifying and Reducing Health Inequities
Making health equity a strategic priority involves spearheading initiatives that change biased mindsets and remove or reduce biases and the number of inequitable processes that result in patient safety events, according to these experts.

Because some of the biases that drive health inequities are implicit, recognizing the impact of such biases within patient populations may be challenging. There are several foundational steps for identifying and reducing inequities in care practices.

Leverage your quality improvement/patient safety data. Patient safety data and analysis are often generalized across patient populations. “The problem with that is it may not identify if there are differences in the quality of care and the approach to safety across different populations,” says Marshall H. Chin, MD, primary care internist and associate director of the MacLean Center for Clinical Medical Ethics, University of Chicago Medicine. “If you’re putting everyone in the same bucket, you may miss a signal from how the marginalized population is being cared for.”

Instead, healthcare leaders can use stratified data to obtain an understanding of the health equity issues within their facilities. Are there differences in length of stay, hospital readmissions and mortality rates specific to different populations?

“You need to look at your own data and segment it in different ways, whether that’s by gender or age, race and ethnicity, social vulnerability, based on where people live, and their socioeconomic status,” says Alisahah Jackson, MD, system vice president of population health, innovation and policy for CommonSpirit Health, Chicago.

“Here at CommonSpirit, we’re already collecting data on certain health outcomes and then overlaying some of these additional demographic and socioeconomic factors,” she says. “Hypertension control, for example, is a huge quality metric used across our entire organization. We’re looking at that data by race, ethnicity and gender.”

Gather information from your workforce and patients. Such stratified data can often be extracted from information systems such as EHRs. If a provider’s current system does not stratify data, this information can be obtained in other ways. “My guess is that most organizations are able to identify with pretty good accuracy some of the most common types of patient safety inequity issues,” Chin says.

Simple tools such as patient surveys can also identify inequitable care practices, says John Ward Molina, MD, corporate compliance officer for Native Health, Phoenix, an outpatient care provider for underserved populations.

The survey should question patients on their likes and dislikes about their clinic or hospital visits, he says. Molina says patients should complete the survey directly after their clinical visit so the information is fresh.

“A healthcare provider’s perceptions, beliefs, attitudes, behaviors and biases have a major effect on patient safety and can determine if that patient receives equitable healthcare or not.”

—Trina Parks, FACHE, RWJBarnabas Health
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“That information is so important,” he says. “This helps in aligning services to what patients need and what communities need.”

**Determine the root cause.** Determining the reason for difference in outcomes within demographic factors is similar to the root cause analysis conducted for a quality improvement initiative—examining the people and processes that are part of the care services, Chin points out.

Chin recommends holding discussions with each set of stakeholders, including caregivers (physicians, nurses, other clinicians) and the patients themselves. This approach may uncover implicit biases that people have for ethnicities or cultures that they are not familiar with.

Reviewing process and policies may also uncover systemic drivers of health inequities, such as communication challenges, Chin says. A patient with limited English proficiency may not fully comprehend a physician’s care instructions, and an interpreter or information in the patient’s native language may not be available to translate the physician’s communication into language the patient can more easily understand.

**Create oversight structures.** To help identify inequities and ensure they are addressed, it is important to create structures that oversee improvement initiatives.

ECRI’s Schabacker recommends dedicating resources, such as by appointing a health equity champion or creating a health equity governance committee.

“Create that person or committee whose sole responsibility is to identify these issues and then put a plan in place to fix it and measure on a frequent basis,” he says.

He also advises making progress on health equity part of management team quarterly or monthly reviews.

Critical to attaining an effective structure is finding someone who has “fire in the belly” for health equity, Schabacker says, meaning someone who is passionate, understands equity, wants to make a difference and can develop an entire team.

“I also recommend that they include one or two doubters,” he adds. When presented with data, doubters will very quickly recognize inequities, and if they can change their mindset, these doubters then become accelerators of equity throughout the organization. “Don’t just surround yourself with people who think like you,” Schabacker says.

**Enact policies that address biases.** Language miscommunication plays a significant role in patient safety events. Organizations should implement guidelines for how to handle communications challenges with patients. If there are already official guidelines, such as use of an interpreter for non-English speaking patients, understanding how these guidelines apply in actual clinical practice is important.

“Most organizations may aspire to those kinds of care practices, but fall short in designing or implementing easy-to-use, convenient interpreter systems for staff and clinical use,” Chin says.

Native Health’s Molina recommends reviewing such policies dealing with inclusive practices at least annually to make sure they reflect the needs of the various populations and whether the workforce is aware of and

“At CommonSpirit, we’re already collecting data on certain health outcomes and then overlaying some of these additional demographic and socioeconomic factors. Hypertension control, for example, is a huge quality metric used across our entire organization. We’re looking at that data by race, ethnicity and gender.”

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Improve cultural competency. A lack of trust between a patient and clinician, sometimes not only based on a communications challenge but also on a provider’s unfamiliarity with cultural customs, often puts patients at a higher risk for a safety event.

Some cultures hold beliefs or customs that may affect their care treatment. For example, many indigenous populations practice “what we call ‘grandmother’s form of care’—the chicken soup, herbs, teas, things of that sort of nature,” Molina says.

Because of this cultural unfamiliarity, educating clinicians and other caregivers on cultural competency may help reduce the chance for events that lead to inequitable care.

“Perhaps the executive team can look at: ‘How can we train our front-line providers to be more engaging or talk about their patients’ cultural beliefs,’” says Molina, who is also an associate professor of family and community medicine at the College of Medicine of the University of Arizona.

“We as executive team members need to train our people to be more engaging of people of different backgrounds and cultures because that’s where we can begin to address this whole concept of equity,” Molina says.

Assessing and addressing the cultural competencies within your organization can also reduce health inequities. The workforce must be aware that inequities exist and of how they might be unintentionally contributing to the problem. For example, a prevalent misconception is that the African American patient population is much more pain-sensitive than other populations, Schabacker says.

“Had we not done that work, I don’t know if that [information] would have surfaced,” Jackson says.

Another idea is to have your equity champion reach out to these marginalized populations and partner with outreach groups. “See what they perceive; listen to what they tell you,” Schabacker says. “You might hear that no one at the hospital speaks Spanish, or there are no Black doctors or nurses.”

“Create that person or committee whose sole responsibility is to identify these issues and then put a plan in place to fix it and measure on a frequent basis.”

—Marcus Schabacker, ECRI
RWJBarnabas Health has committed to delivering culturally sensitive and inclusive care to all patient populations, according to Parks. The health system has, for example, implemented sensitivity training for employees on the LGBTQ community, which Parks says experiences lesser health outcomes than heterosexual counterparts.

“To best serve our patient population, including the LGBTQ+ community, we have focused our efforts on cultural humility, which is adopting a learning attitude to continuously gain greater insight into how we lead our strategic initiatives by understanding how to best serve the LGBTQ+ population,” Parks says.

“Additionally, we have implemented ‘preferred name’ and ‘sex at birth’ into our electronic medical records at the point of entry and expanded the option for one to designate their ‘preferred gender.’”

Recruit diverse healthcare workers. Recruiting health care workers from underrepresented groups can help alleviate the patient safety events that result from cultural incompetency.

This is another area where RWJBarnabas has focused.

“Our president and CEO, Barry Ostrowsky, instituted a new SBAR—situation, background, assessment, recommendation—process for ensuring that our leadership teams better reflect the diversity of the communities we continue to serve,” Parks says. “Through the new SBAR process for all leadership positions—defined as vice president-level and above—if an internal or external nonminority or nonfemale candidate is selected, the hiring executive has to complete an SBAR outlining a clear rationale for the new hire in advance of an offer.”

The SBAR process should include resources used for sourcing candidates, the demographic breakdown of the candidate pool that identifies race and gender, and the premise on which the hiring decision was made.

“This approach has allowed us to be intentional in our hiring practices to increase the diversity in our organizations,” she says.

Embracing Health Equity

Perhaps first and foremost reducing inequities begins at the top, with an awareness of and commitment to reducing biases and care practices that, often unintentionally, either exclude or do not go far enough in considering the needs of marginalized populations, says Chin.

“The vast majority of clinicians, administrators and staff want to do the right thing and provide the best possible safe care to everyone,” he says.

Identifying health inequities and determining their causes are important steps in the process, but not the only ones.

“Equally important are what I would call ‘cultural issues,’” says Chin. “Does your healthcare organization truly have a culture of equity, where equitable care and safety are truly valued and everyone in the organization is supported to provide that? Do not be afraid to say, ‘This is what we stand for in terms of equity, justice and fairness. Our organization’s mission is really to provide safe, equitable and quality care to everyone.’”

Prioritizing health equity across the organization empowers leadership to more wholly fulfill that mission. “It’s a leadership challenge,” he says, “and a leadership opportunity.”

Karen Wagner is a freelance healthcare writer based in Forest Lake, Ill.
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Hot Topics

The Hot Topic sessions at Congress highlight best practices in some of the most critical areas of healthcare leadership. Note: Hot Topics are on Tuesday (3) and Wednesday (2). There are five Hot Topic sessions.

**Driving Innovation for New Cybersecurity and Authentication Technology**

As healthcare organizations work to prevent and recover from ransomware and other cyberattacks, health systems must continue to drive innovation to stay ahead of the curve to protect patient information and healthcare’s infrastructures. Join Rachel Wilson, managing director and head of cybersecurity for Morgan Stanley, as she provides insights into the latest innovations in cybersecurity and authentication technology, and the lessons that healthcare leaders can learn from the financial industry as stewards of the most sensitive information for individuals and their families.

Rachel Wilson
Managing Director/Head of Cybersecurity
Morgan Stanley

**Leveraging Technology to Address Healthcare’s Biggest Challenges**

The future of healthcare is at the intersection of medicine, public health and information technology, collaborating to improve the health of individuals and entire communities. Join Karen DeSalvo, MD, chief health officer at Google, for an engaging fireside chat where she will provide insights into how collaborations between big tech and healthcare can tackle some of today’s biggest challenges, from combatting the COVID-19 pandemic to improving social determinants of health.

Karen DeSalvo, MD
Chief Health Officer
Google

**Healthcare Delivery Models of the Future**

Individuals and families face unprecedented challenges in accessing high-quality, affordable healthcare. From the onset of the COVID-19 pandemic to rising healthcare costs and healthcare inequities, patients as consumers are increasingly demanding more convenient, affordable care without sacrificing quality. Join Marcus Osborne, former senior vice president of Walmart Health, as he discusses how healthcare delivery models are evolving to meet consumer demands, and how this will impact patients, providers, and the healthcare system as a whole now and in the future.

Marcus Osborne
Retail Health Expert
Former Senior Vice President
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With over 150 interactive educational sessions and 15 networking opportunities, the Congress on Healthcare Leadership has something for all healthcare leaders. Learn more and register at ache.org/Congress

**Wednesday**

*Recruiting and Retaining Key Talent in the New Age of Work*

Our organizations and their leaders are in a state of transition and transformation, whether they want to admit it or not. People, not technology, will determine how these changes unfold. Organizations that can recruit, and retain, the “best talent” will have a competitive advantage, but how can leaders do so effectively? Through her expertise as an executive recruiter and builder of talent processes, Ginny Clarke pulls the curtain back on how to be successful throughout the employee life cycle.

**Ginny Clarke**
Former Director, Executive Recruiting
Google

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*American Hospital Association Health Policy & Legislative Update*

Questions surround the 2022 election year, the ongoing impact of COVID-19 on healthcare policy, and how Americans will deal with a variety of issues from increasing costs of care to infrastructure changes. The ongoing discussions and confrontations that occur between the executive, legislative and judicial branches of the government provide additional murkiness to the nation’s healthcare agenda. Join in this lively presentation that will be led by Stacey Hughes—AHA’s front seat to the healthcare policy debate.

**Stacey Hughes**
Executive Vice President, Government Relations and Public Policy
American Hospital Association
As healthcare leaders continue to prioritize the importance of modeling professionalism within their organizations, recognizing the existence of professionalism at both the individual and organizational levels will assist with achieving this critical healthcare leadership competency.

Defining Professionalism
Professionalism is a core competency of healthcare leadership; however, any attempt to find a uniform definition of professionalism can be a challenge. The concept of professionalism in healthcare tends to be understood in relation to the actions of specific professionals such as physicians, nurses and chaplains; they have identified guidelines that serve as standards for their behavior. This is also true for healthcare executives. ACHE members’ actions, for instance, are guided by the organization’s Code of Ethics. Executives can personally review their professional behavior by using ACHE’s Ethics Self-Assessment. Such professional standards and assessment tools provide insightful guidance to an individual executive’s behavior.

To increase the effectiveness of creating a culture of professionalism, healthcare leaders can deploy strategies to establish and sustain professionalism at the organizational level. Organizational professionalism becomes a critical consideration when it is required to achieve individual professionalism. To achieve individual professionalism, healthcare leaders must ensure that their organizations create a culture and working environment in which professionals can comfortably demonstrate their values of professionalism in a supportive and aligned environment. A healthcare organization that creates a culture of professionalism at the organizational level facilitates the ability of individuals to behave in a professional manner.

To achieve a culture of professionalism, a synergy between individual and organizational professionalism must exist.

4 Domains for Organizational Professionalism
“The Charter on Professionalism for Health Care Organizations,” published online in the Jan. 10, 2017, issue of Academic Medicine, is a useful resource to help foster organizational professionalism. Written by Barry E. Egener, MD; Diana J. Mason, RN, PhD; and Walter J. McDonald, MD; et al., the charter is a framework of consensus-based domains from which an organization can develop a moral compass necessary to sustain a “culture of professionalism.” The charter—developed by physicians, ethicists, nurses and organizational administrators—outlines tenets for both professional behaviors and behaviors that support professionalism.

Addressing each of the charter domains will require a potential rethinking by individuals, teams, committees and governing boards within organizations.

The charter can serve as a blueprint for leaders seeking to build and assess whether organizational professionalism is reflected throughout their organization (see: tfme.org/organizational-professionalism/).

As described in the charter, there is a growing understanding that efforts to exhibit professionalism throughout an organization will more likely be realized when leaders support and implement those efforts by incorporating the following domains of organizational professionalism:

Patient partnerships. A charter-committed organization is patient-centered and collaborates with
patients to ensure outcomes that are consistent with their goals and values. Organizations that integrate person-centric principles will experience enhanced patient trust and loyalty to the organization. For example, an organization that partners with patients to reduce wait times for appointments would support listening to patient feedback, addressing patient concerns and striving to continuously improve quality of care consistent with the organization’s values and goals.

**Organizational culture.** Through effective leadership, an organization can create an environment of shared beliefs and behaviors that reflect the priorities of patients and staff to provide high-quality care. As described in the charter, “While many professional entities provide guidelines for behavior of individuals within their disciplines, it is the responsibility of leadership to describe a healthcare organization’s desired culture, and create structures that support it and ensure accountability.” Healthcare leaders who model the professional behaviors they expect to see throughout their organization create a culture in which individual professionalism behaviors are not only practiced but also expected. For example, a healthcare leader who expects the workforce to greet others with a smile and pleasant greeting as they pass one another in the halls of the organization must consistently demonstrate such behavior to promote an accepting and inviting culture.

**Community partnerships.** A charter-focused organization collaborates with other healthcare organizations throughout the community as well as policymakers and businesses to

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**Congratulations to the inaugural Thomas C. Dolan Career Accelerator Program Scholars**

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create healthy communities. Achieving this domain requires using a systems approach to address social factors that undermine the health of the community and joining together in partnership with others in recognizing barriers to health and designing strategies to improve a community’s health. An example of how this domain might be implemented is the tangible incorporation of feedback from the community generated by solicited quantitative and qualitative responses. Healthcare leaders who broadly encourage their communities to voice their opinions and consistently provide explanations as to why suggestions are or are not adopted are making a concerted effort to incorporate this domain of organizational professionalism.

**Operations and business practices.** An organization that has adopted this domain is one that prioritizes evidence-based care and patient and staff safety; it is not an economic-driven organization. The organization’s operational practices are driven by a fiduciary commitment to patients and ethical business practices. This domain reflects the growing acknowledgement that an ethically grounded and focused organization enhances the organization’s brand along with patient loyalty and staff morale. For example, organizations need to focus on their financial well-being; however, public trust in the organization can be compromised when the organization is seen as acting in the organization’s financial interests rather than the patient’s best interest. As a result, healthcare organizations should avoid financially motivated activities that are not in synergy with promoting individual and organizational professionalism and aligned with the organization’s mission, vision and values.

**Strategies for Implementing the Charter** The domains outlined in this article provide a useful framework to understand and achieve a professionalism-based organization that supports the ultimate goal of delivering high-quality, value-based care for patients. Strategies for implementing the various domains include:

- Recognizing the charter domains as important components of the organization’s culture.
- Identifying specific approaches to designate as examples of promoting a sound organizational culture.
- Identifying specific metrics (many of which are already being measured) to designate as examples of organizational professionalism domains.
- Promoting awareness of the charter domains as they relate to individual professionalism, which will ensure the workforce is committed to demonstrating both individual and organizational professionalism.
- Employing the charter as a teaching tool for bringing life to the mission, vision and values throughout the healthcare organization.

Healthcare leaders routinely grapple with operational challenges that have the potential to interfere with laudable efforts to demonstrate individual and organizational professionalism throughout their healthcare organizations. Many of the challenges confronting executives relate to professionalism at the organizational level.

Just as individuals serve as moral agents in making decisions, so do organizations when an action is taken on behalf of the organization.

“The Charter on Professionalism for Health Care Organizations” provides a tool to foster the alignment of a healthcare organization’s mission and values within today’s healthcare delivery systems.

Addressing each of the charter domains will require a potential rethinking by individuals, teams, committees and governing boards within organizations.

An effort to reframe an organization’s demonstration of individual and organizational professionalism provides an opportunity for healthcare organizations to meaningfully collaborate to fulfill their true mission of promoting the health of the populations served.

Julie L. Agris, PhD, JD, FACHE, is associate professor/director of the health management programs at Stony Brook (N.Y.) Medicine (julie.agris@stonybrookmedicine.edu). William A. Nelson, PhD, HFACHE, is director/professor of the Ethics and Human Values program at the Geisel School of Medicine at Dartmouth, Hanover, N.H. (william.a.nelson@dartmouth.edu).

**Editor’s note:** To access the ACHE Ethics Self-Assessment, go to ache.org/EthicsSelfAssessment. See the July/Aug 2021 issue for a print version.
How do you integrate adaptability as a core competency of your leadership team? How do you know you are making meaningful inroads into improving patient care?

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The challenges presented by the COVID-19 pandemic were felt most acutely in the country’s health systems. As the first cases of COVID-19 were being reported in the U.S., Allina Health leaders were working to prepare its staff and hospitals in Minnesota and western Wisconsin. Beyond the clinical challenges of responding to a novel virus for which medical treatments were being developed in real time, global shortages strained Allina Health’s supply chains. As COVID-19 patients filled hospital beds, intensive care units and ambulances, the organization’s clinics sat largely empty as it worked to expand its surge capabilities and virtual care platforms. At the peak of disruption, patient service revenue losses reached approximately $40 million per week.

Current Status

Fast forward to today. Hospital and clinic patient volumes have recovered to more than 95-100% of pre-pandemic volumes. Virtual care services have expanded to an average of 6,000 cases per week, from around 70 cases per week prior to the pandemic. Ambulatory surgery center capacity was increased to provide more convenient outpatient surgical care, and through the Home Hospital Care program, length of stay and total cost of care decreased, readmissions were reduced, and patient satisfaction increased. Additionally, in the past two years, Allina Health entered into two value-based partnerships with key payers in its market, further aligning payment with care models.

Every initiative and investment is underscored by Allina Health’s mission to provide Whole Person Care—mind, body, spirit and connection to community—to all those served.

As of Sept. 30, 2021, operating margins have turned positive again to 3%, with an operating income of $107.6 million. As a nonprofit, this enables the organization to reinvest in the workforce and the care delivered to the community. Even as the pandemic and its long-term effects continue—and despite losing more than $36 million in 2020—Allina Health is strongly positioned to accelerate progress on its core strategic imperative to be a high-value, seamless integrator of care.

Allina Health’s leadership team has maintained a constant focus on three key areas that enabled it to navigate incredibly difficult and dynamic times: a strong culture of performance, a consistent and strategic road map, and an unwavering commitment to provide Whole Person Care for the workforce, patients and their loved ones.

Strong Culture of Performance

Allina Health’s results are due to a performance culture that is firmly anchored around safety, continuous improvement and infrastructure to further enable the organization’s systemic capabilities. Prior to the pandemic, it embarked on a journey to become a high-reliability organization, making safety the core of everything it does, from care teams to corporate functions. With safety serving as the North Star, daily tiered huddles foster learning, sharing of best practices and the means to measure results through the Allina Improvement System.

Investments in areas like the patient care Access Center, Customer Experience Center, centralized supply chain and consumer insights data allow staff to collaborate to best support care teams and patients. Operational and financial performance capabilities can now pivot quickly, allowing the organization to maintain discipline and focus, even during challenging times.
A Strategic Road Map
The second area of focus has been maintaining a clear and consistent vision of being a high-value, seamless integrator of care. The strategic blueprint built to support that vision was established long before COVID-19, and though the pandemic presented many challenges, it also created many opportunities to accelerate initiatives and validate the path forward.

As Allina Health looks ahead, the tactics being deployed are intentional to transform care delivery for the better. In addition to the strategic investments in telehealth, ASCs and care model innovations like Hospital at Home, complex care programs like neurology and cardiovascular care will remain strengths. Additionally, the Allina Health Cancer Institute—born from a vision to redefine cancer care in the Twin Cities by eliminating fragmented care and offering affordable, accessible and seamlessly connected cancer care closer to home—is coming to fruition. The focus on consumers, value and integrated care across the healthcare continuum will remain, moving beyond a post-pandemic future.

Whole Person Care
Every initiative and investment is underscored by Allina Health’s mission to provide Whole Person Care—mind, body, spirit and connection to community—to all those served. Whole Person Care isn’t just a future initiative; it is an intentional shift in the organization’s vision for care delivery. And, while not born from the pandemic, COVID-19 elevated areas of recommitment to focus on as an organization.

Allina Health is dedicated to caring for its front-line caregivers and all employees who make the delivery of essential services possible. During the pandemic, immediate financial support and other benefits were provided to employees who experienced financial and work-life balance challenges. That support and care continues through well-being and employee-assistance programs, as well as financial and benefit incentives to help employees focus on their own health.

Allina Health is also committed to continuing to advance its diversity, equity and inclusion road map across the organization’s four key roles of provider, employer, investor and community partner by establishing a dedicated structure to ensure its efforts move forward. Through employee councils led by the CEO, operations committees and employee resource groups, Allina Health is unified by a collective goal of working together to eliminate systemic inequities and racism in all that it does.

With the benefit of time for reflection, the dedication, resilience and creativity of the entire Allina Health team’s singular focus of serving the community—despite the many challenges faced throughout the past nearly two years—is truly inspiring. Senior leadership is grateful for the continued commitment of the entire staff to Allina Health’s mission to provide the highest quality Whole Person Care to all those it is privileged to serve. ▲

Lisa Shannon is president/CEO, Allina Health Minneapolis, and an ACHE Member (lisa.shannon@allina.com). Ric Magnuson is executive vice president/CFO, Allina Health, Minneapolis (richard.magnuson@allina.com).
Cape Fear Valley Health System believes one way it can improve patients’ health and experience is to make every effort to train a confident first-class physician workforce that is likely to remain in rural North Carolina. Increasing the academic research and teaching opportunities for physicians through a larger medical education program will also attract more established physicians to the area.

The challenge, however, for many organizations throughout the United States is physician retainment, which has become increasingly difficult due to the national physician shortage, particularly in rural communities.

Addressing Physician Shortages
The United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including shortfalls in both primary and specialty care, according to the Association of American Medical Colleges. The organization's data was released in 2021 and based on a survey it conducted prior to the pandemic.

Cape Fear Valley Health System is located in Fayetteville, N.C., and demand growth from 2019 to 2034 is projected to be largest in the South at 62,900 full-time physicians needed, according to the Association of American Medical Colleges.

The health system, which serves a seven-county region of southeastern North Carolina, knows full well the physician shortage situation, as its CEO, Michael Nagowski, and board of trustees realized that a medical residency program was instrumental to a long-term physician recruitment strategy for the region. That is why four years ago, Cape Fear Valley began developing residency programs with the intent to retain physicians.

Since its inception, the residency project has represented a spirit of collaboration across the health system and local community. Physicians often put down roots where they complete residency/fellowship training. So far, this strategy is paying off for Cape Fear Valley, as half of its recent resident graduates have decided to stay and practice locally. Much of this recruitment success is due to the people who live and work in the region.

Graduate medical education faculty ensure residents are exposed to many extracurricular activities within the community, thus encouraging them to make lifelong friends and connections. Residents are accepted from all over the country, and the local population has shown these young doctors a hometown welcome, enveloping them in a strong feeling of community. Fayetteville’s Southern hospitality has absolutely contributed to the health system's post-residency retention rates.

Expanding to Meet Growing Needs
This summer, Cape Fear Valley Health System will open the Center for Medical Education. This new $33 million facility will house an expanding medical education program, the Neuroscience Institute, a food court and a 500-seat auditorium—and will still have shell space for future growth. The five-story, 120,000-square-foot facility broke ground in January 2021. The project was developed with a focus on creating the best academic environment for residents and staff members throughout their experience at Cape Fear Valley. The Center for Medical Education will include a state-of-the-art simulation lab, classrooms, space for clinical trials, and a large auditorium that will be suitable for academic or community needs.

The new center deepens the organization's commitment to educating the next generations of physicians for rural North Carolina. It's estimated the facility and its programs will help create 900 jobs in the next 10 years and generate $500 million for the local economy.

By the end of the year, 12 residency/fellowship programs will be in place in areas that include internal medicine, general surgery, cardiology, and adolescent psychiatry fellowships, among others. The Center for Medical Education will enable Cape Fear Valley to more
than double the size of the current program, training up to 300 residents every year and adding more residency programs.

**Strengthening Positive Effects on Patient Satisfaction**

Beyond the residency program, the new facility’s Neuroscience Institute will allow for expansion of the neurology program, which treats disorders such as strokes, aneurysms, epilepsy, spinal cord injuries, brain tumors and traumatic brain injuries. The new state-of-the-art facility will help to attract and retain highly trained neurologists and neurosurgeons and provide a full range of diagnosis, treatment, education and research so patients don’t have to travel far to get the care they need, resulting in better outcomes. The Neuroscience Institute will advance diagnoses and treatment in Cape Fear Valley’s service area as well as open new possibilities for research and education.

Residents are very involved with the everyday care of patients, and the learning physicians have a positive effect on patient satisfaction. The residents and attending physicians work together to bring a more academic approach to medicine, including the latest medical breakthroughs and research.

Though the Center for Medical Education is located at the main campus in Fayetteville, its impact will be felt throughout the entire health system, which includes eight hospitals located in four surrounding counties and 65 outpatient clinics that serve a larger multicounty region. As the residency and medical education program expands with the new facility, the organization expects to continue to extend its ability to fill critical patient needs with a variety of services.

The new Center for Medical Education is part of the larger commitment by Cape Fear Valley Health to bring accessible quality healthcare to the region. ▲

Daniel Weatherly is COO, Cape Fear Valley Health System, and an ACHE Member (dweatherly@capefearvalley.com).
The delivery of hospital-level care in a patient’s home, instead of in a traditional hospital, has come to the forefront in over 185 hospitals across the country in under a year, according to the article “Early Uptake of the Acute Hospital Care at Home Waiver” published Oct. 26, 2021, in *Annals of Internal Medicine*.

Hospitals around the country are ripe for transformation to deliver acute care in their patients’ homes.

The model stems from decades of research showing that when a specialized team delivers care at home, patients are readmitted less often, have improved mobility and incur less cost, according to the article “Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial,” published Dec. 17, 2019, in *Annals of Internal Medicine*.

In addition, patient and caregiver experience are higher, and hospital-acquired disability is likely lower, especially for older adults who are susceptible to iatrogenic complications, according to the article “Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences,” published Aug. 1, 2018, in *JAMA Internal Medicine*, and the article “Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-Level Care at Home for Acutely Ill Older Patients,” published Dec. 6, 2005, in *Annals of Internal Medicine*.

The spread of this care model has been due in part to a waiver issued in November 2020 by the Centers for Medicare & Medicaid Services that sought to improve hospital capacity by waiving the requirement for overnight nursing and paying a hospital at parity for a diagnosis related group.

Brigham and Women’s Hospital has practiced home hospital care since 2016. Its efforts have evolved from a 20-patient pilot program staffed by a single daily physician and nurse, to a larger randomized controlled trial and, most recently during the pandemic, to a larger team caring for over 500 acutely ill patients per year with capacity approximately the size of a typical medicine ward.

Just as in the hospital, operational challenges abound for home hospital care—some unique to the model and others familiar to seasoned hospital administrators. The following are five key operational strategies Brigham and Women’s Hospital has learned in the hope others will accelerate their home hospital efforts quickly.

1. **Secure Executive Commitment to Home Hospital**

Executive sponsorship has been crucial to Brigham’s success. Leadership that recognizes the financial and resource support required—and realistic timelines for success—can make or break a program. Clear communication with leadership is essential. Common metrics used to portray home hospital performance are expected volumes and bed days. These metrics should be created and shared with leadership regularly. Showing the value of home hospital also is crucial. For example, showing how home hospital is helping to decant a bursting ED and celebrating patient stories can help solidify executive commitment.

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*This column is made possible in part by Cerner Corporation.*
2. Make Home Hospital Part of the Hospital’s Pandemic Playbook
During the first surge of the COVID-19 pandemic in Boston, Brigham’s home hospital team treated 65 acutely ill patients, freeing 419 bed days for the hospital with a 3.1% escalation rate (the rate at which a patient required a higher level of care and returned to the hospital). This was accomplished with a relatively small team: one daily physician, one to two daily nurses and one mobile integrated health paramedic. Consider your home hospital team an agile unit that can expand or contract based on the hospital’s needs, without the need to build a new tower or wing of your hospital.

Studies and institutional experience have shown this care model not only hits the Quadruple Aim, but also can make financial sense.

3. Go All-In
Home hospital programs find the most success when given plenty of support. The program should be staffed with medical and nurse directors, administrators and a site coordinator, which allows clinicians to work at the top of their licenses and facilitates volume. A failed model, on the other hand, is likely when physicians and nurses are asked to practice home hospital care “part-time” while performing other responsibilities or in addition to an already full day of work. Instead of realizing the barrier is an appropriately resourced team, hospital leadership might erroneously consider the model a failure.

4. Involve Every Corner of the Hospital
Think beyond the typical departments (e.g., laboratory, emergency medicine) you will need to work with to make a home hospital program successful. You may not think the hospital’s parking team is important to home hospital’s success, but it is. The logistics of how a home hospital team enters and exits the hospital, which special parking spots they can use, and how they can orchestrate a drive-through option all make big differences to operational efficiency.

Brigham’s home hospital team has had the great opportunity to meet individuals from nearly every corner of the hospital because of this care model. Bringing leaders of these diverse teams together to demonstrate each team’s importance to the model is crucial.

5. Prioritize Staffing
Home hospital clinicians practice within a unique discipline: These specialists are trained in acute care but are comfortable practicing in the community and in patient homes. This requires significant cross training that often happens through a careful preceptorship and a competency-based assessment. Given the relatively small number of full-time equivalents that most home hospitals employ, creating backup systems and building in capacity to weather staff transitions can improve operations and help maintain institutional memory. Brigham, like other organizations, has diversified its staffing—with paramedics, for example—to deepen the bench.

Hospitals around the country are ripe for transformation to deliver acute care in their patients’ homes. Studies and institutional experience have shown this care model not only hits the Quadruple Aim, but also can make financial sense. With solid strategic planning, hospitals can lead an agile restructuring of how acute care is delivered in the United States.

Robert Boxer, MD, PhD, is medical director for clinical operations for Brigham’s home hospital (rboxer@bwh.harvard.edu); David Levine, MD, is medical director for strategy and innovation for Brigham’s home hospital (dmlevine@bwh.harvard.edu); and Thomas Walsh is vice president, inpatient operations and analytics, planning, strategy and improvement, Brigham and Women’s Hospital, Boston (twalsh1@bwh.harvard.edu).

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As Medicare Advantage turns 25 years old in 2022, the Centers for Medicare & Medicaid Services expects there to be 29.5 million enrollees in MA plans this year—up from 26.9 million in 2021. That’s 47% of the Medicare-eligible population, although enrollment varies at the state and county levels. Given the program’s popularity, provider organizations can expect to see more opportunity to contract with Medicare Advantage for seniors and possibly other populations, too.

Medicare Advantage is one of the most significant programs offered through Medicare and certainly among its most visible. In the latest annual election period that ended Dec. 7, advertising of MA plans to potential enrollees was ubiquitous. It’s understandable: The MA market is highly competitive and differentiation among the plans is challenging. In 2022, enrollees have an average of 38 plans to choose from out of 3,800 offered nationwide, and every MA plan is required to cover everything that Medicare Fee-for-Service covers (except for hospice care), including emergency and urgent care.

Further complicating the spectrum of choices available are the benefits included with MA plans and different types of managed care models. Ninety percent of plans include prescription drug coverage (Medicare Advantage prescription drug plans) along with other popular benefits (see chart on this page). 58% of the plans operate a health maintenance organization plan, 29% offer a preferred provider organization plan and the rest are hybrids. Five companies control 77% of the MA marketplace, with investor-owned sponsors providing coverage of 71% of enrollees. New venture capital-backed startups account for 241,000 lives (1% of national enrollment).

**Enrollment Variation**

Enrollment in Medicare Advantage plans is forecast to reach 50% of the entire Medicare population by 2029 or before, according to the Congressional Budget Office; however, enrollment varies widely around the country. For example, Medicare Advantage grew 9.6% from 2020 to 2021 at the same time enrollment in original Medicare fell 2.6%. Enrollment in MA plans has more than doubled since 2011. And, in 2021, 60% of MA enrollees paid no supplemental premium (other than the Part B premium): 5% paid less than $20 per month, 17% paid $20–$49 per month, 12% paid $50–$99 per month and 6% paid more than $100 per month.

Additionally, 19% of enrollees are in group MA plans offered by employers and unions for their retirees, representing a disproportionately large share of MA enrollees in nine states:

### Benefits Included in Medicare Advantage Plans

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth</td>
<td>94%</td>
</tr>
<tr>
<td>Eye exams or glasses</td>
<td>79%</td>
</tr>
<tr>
<td>Dental care</td>
<td>74%</td>
</tr>
<tr>
<td>Fitness</td>
<td>74%</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>72%</td>
</tr>
<tr>
<td>Over-the-counter therapies</td>
<td>61%</td>
</tr>
<tr>
<td>Meals</td>
<td>39%</td>
</tr>
<tr>
<td>Transportation</td>
<td>34%</td>
</tr>
<tr>
<td>Home care</td>
<td>4%</td>
</tr>
</tbody>
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Alaska (100%), Michigan (49%), West Virginia (44%), New Jersey (40%), Wyoming (36%), Illinois (35%), Maryland (35%), Kentucky (34%) and Delaware (31%).

Overall, enrollment varies widely by state, ranging from 1% in Alaska and Wyoming to over 40% in 19 states (Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Michigan, Minnesota, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Wisconsin) and Puerto Rico. (These overall state enrollment percentages include the enrollees in group MA plans mentioned in the preceding paragraph.)

Enrollment also varies widely by county from less than 1% to more than 70%: In 117 mostly urban counties, which account for 5% of the Medicare population, more than 60% of all Medicare beneficiaries are enrolled in Medicare Advantage. In comparison, in 508 mostly rural counties, which account for 3% of Medicare beneficiaries nationwide, fewer than 10% of beneficiaries are enrolled in Medicare private plans.

Regulatory Oversight
In 2022, regulatory oversight of Medicare Advantage is likely to increase in the following three areas:

Overpayments. Regulators are taking a close look at systemic upcoding, which the Office of Inspector General in the Department of Health and Human Services estimates cost Medicare $140 billion in excess payments to 142 plans in the last decade. The Five-Star Quality Rating System methodology used by Medicare to award bonuses to plans is likely to change as a result: Last year, 81% of all plans received a four- or five-star rating, making them eligible for a bonus, versus only 5% that received one or two stars.

Supplemental coverage. CMS is monitoring access to and the efficacy of the supplemental benefits enrollees receive to ensure equitable access and clinical benefit. A particular focus is the special supplemental benefits for chronically ill enrollees.

Competition in the MA market. Officials in the Department of Justice and the Federal Trade Commission are monitoring consolidation in the MA market and emergence of private equity-backed startups.

What’s Ahead?
For hospitals, health systems, physician organizations and long-term care providers, monitoring changes to the Medicare Advantage program is vital to planning. There are two immediate opportunities for these providers to participate in MA plans afforded by the growing popularity of the program.

Platform for senior health. Providers can approach MA contracting as an opportunity to innovate their senior health programs, leveraging facilities, digital connectivity and care coordination around a “whole person care” model for patient relationships. Contracts with MA plans require clinically integrated provider networks, wherein primary and preventive health services are intensified, social determinants of health are addressed, and referrals to needed specialty care are closely monitored for medical necessity and cost effectiveness.

Special needs populations. There are also opportunities for providers to contract with MA plans for services needed by enrollees in residential care facilities. These services include adult day programs, in-home personal care services, over-the-counter therapies, home safety modifications, wheelchair ramps and stair rails, meal delivery, transportation, and palliative and hospice care. Notably, 4% of MA enrollees live in residential care facilities where CMS designates Special Needs Plans for people with specific diseases, e.g., diabetes, for certain healthcare such as renal disease or limited incomes (dual-eligibles). MA sponsors are required to offer services included in Medicare Fee-for-Service for SNPs and often include additional services targeted to each population, which is a focus of increased differentiation for MA plans.

Medicare Advantage is managed care for seniors and potentially a template for other populations. It’s certain to play a central role in the U.S. health system’s future. ▲
Developing leadership talent is a significant challenge facing healthcare; it is tough to address, as the exit of industry leaders looms large in light of career-defining pressures created by the pandemic. The pandemic’s timing coincides with many baby boomers entering retirement age. This has the potential to leave a vacuum of power and experience that neither of the two generations after them can address on their own. The number of Generation Xers is too few to fulfill the demand, and while some millennials are exceptionally qualified to take senior positions today, most are still developing and honing their skills.

As healthcare organizations work to fill leadership positions and prepare the next generation of leaders, what traits will be most important for those leaders to possess? This column will define some key competencies that allow for the full realization of leadership potential. It also will describe an organizational leadership framework in place at Luminis Health, a 741-bed health system based in Annapolis, Md., and tools for leaders to consider using on their career development journeys.

The information provided likely will be helpful to an organization trying to develop a plan to build leadership competency and succession. It also may be relevant for a high-potential or in-development leader ready to undertake his or her next challenge in healthcare.

**Traits for Aspiring Leaders at all Stages**

**Entrepreneurship:** Develop an entrepreneurial mindset aimed at meeting others’ needs.

Although it seems to be part of a new vernacular, “entrepreneurship” in healthcare is hardly new. In her book *Unlikely Entrepreneurs, Catholic Sisters and the Hospital Marketplace 1865–1925*, Barbra Mann Wall shares the story of a 27-year-old Irish immigrant nun who sailed across the ocean in 1877 and would later become administrator of a major Catholic hospital in the U.S. That nun, Sister Lidwina Butler, would ultimately lead two different hospitals, and her second stint as a hospital administrator would last 18 years.

Her literal and figurative journeys defined her and many other religious women who set sail from Ireland and other European countries and some who relocated from within the United States to serve the healthcare needs of others. The women who made those journeys also helped set the standard for the modern healthcare leader: to create and sustain a robust health infrastructure and care models to take care of the vulnerable, their families and communities. Their model of entrepreneurship was as relevant then as it is today. They carefully and systematically studied their communities to identify unmet needs and focused relentlessly on meeting those needs—traits today’s leaders should aspire to as well.

**Accountability:** Be accountable to yourself and others.

For years, author Cy Wakeman has proposed that accountability—which she describes as the mindset to exert control over one’s circumstances and embracing reality—increases individual performance. Embracing reality and rejecting the urge to fill in the blanks with biases and drama are timeless characteristics that will help leaders succeed.

**Trust and Trustworthiness:** Trust and be worthy of the trust of others.

Wakeman’s research suggests a correlation between accountability and trust. Accountable employees and leaders tend to trust the organizations where they work. We can infer that leaders also increase trust within their teams by promoting accountability.

In their Sept. 8, 2016, article in the journal *Business Ethics: A European*...
Review, authors Alvaro Lleo de Nalda of the University of Navarra, Manuel Guillen of the University of Valencia, and Ignacio Gil Pechuan of the Polytechnic University of Valencia, discuss their research on the influence of three factors that influence the trust between managers and subordinates. Their review of the literature on trust and their own research confirmed that ability, benevolence and integrity are key predictors of a leader’s capacity to garner the trust of subordinates. They use the widely accepted definitions of these terms as follows:

- **Ability**: The skills and knowledge necessary to do one’s job.
- **Benevolence**: The demonstration of caring for those under one’s leadership, and loyalty to them for reasons not related to self-interest.
- **Integrity**: The adherence to sound ethical and moral principles (including an organization’s articulated values) and following through on one’s word.

Though organizations have multiple ways in which to influence the degree of trust employees have in them, there is no variable more able to impact trust than the immediate supervisor.

**Higher Purpose: Connect to the mission and find a higher purpose at work.** In their book *Option B*, Adam Grant and Sheryl Sandberg speak about the importance of finding meaning at work. For those of us in the healthcare workforce, well-being is dependent on the healthy integration of life and work. As a generation of millennials engages in leadership pursuits, many also are experiencing how life and work are now permeating each other. They, like Gen X and baby boomers, realize the importance of what we do matters beyond profits and losses and that we can impact the lives of others for the better, thereby increasing fulfillment with work. To do work that matters also increases one’s ability to experience happiness and joy in life and work.

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**Embracing reality and rejecting the urge to fill in the blanks with biases and drama are timeless characteristics that will help leaders succeed.**

**A Leadership Framework**

Luminis Health has developed its Team, Change and Business leadership framework as the foundation of its efforts toward leadership development. Leaders who attend training or perform developmental activities intentionally tie what they have learned into this framework. This balanced approach ensures every aspect of a leader’s competency is appropriately supported and developed.

The TCB framework informs the identification and development of high-potential leaders. It also helps the organization achieve effective succession planning. Luminis Health’s Leadership Essentials, one of the mechanisms for leadership development based on the TCB framework, aims to develop a balanced set of competencies common to all leaders in the organization.

Additional developmental opportunities seek to create opportunities for participation in enterprise priorities by emerging leaders identified as high potentials in the organization. These “HiPos” are identified and vetted through a robust process of inclusive and transparent deliberations that ensure each of the leaders identified exhibits potential for growth and is aligned with the values of the organization.

**Tools for Team and Self-Development**

As part of their development, leaders at Luminis Health become versed in principles of mindfulness and well-being. Leaders also use talent-measurement tools to uncover their strengths, help them lead with those strengths, as well as celebrate and capitalize on the strengths of others on their teams. The organization also administers emotional intelligence competency assessment tools. In addition, it offers opportunities for leaders to discuss the results revealed by both tools individually and in groups led by certified facilitators.

As the healthcare field continues to evolve, the next generation of leaders will need to be well prepared for what lies ahead. With these leadership traits in mind, and with rigor and attention to leadership development, healthcare organizations will be able to continue to care for their patients and improve the health of the communities they serve while providing career opportunities in which leaders and staff can thrive.

J. Manuel Ocasio, FACHE, is chief human resources officer, Luminis Health, Annapolis, Md. (mocasio@aahs.org).

**Editor’s note:** For additional tools and resources on healthcare competencies, including *The ACHE Healthcare Executive Competencies Assessment Tool*, visit ache.org/LeadershipCompetencies.
A Strong Partnership Can Achieve Bolder Goals

Survey reveals need for more aggressive plans for the future.

Key takeaways from The Governance Institute’s 2021 biennial survey demonstrate that most healthcare organizations were able to implement rapid changes, with more work needed on succession planning, diversity and inclusion, and community benefit and advocacy efforts.

A diverse board can better help the organization fulfill its community health needs.

This article focuses on lessons from the survey results we find to be most relevant to the board-CEO partnership and applicable to areas where we feel this critical dyad should be focusing their efforts in the coming years to meet urgent strategic goals faster and more effectively.

Pandemic Effects on Governance

The survey respondents widely agreed their CEOs and boards were both well-prepared to handle the pandemic crisis and also to lead their organizations effectively through it. Although it should be noted that the pandemic is not yet over and CEOs were the most typical respondents to the survey (reflecting a likely bias toward more favorable performance), news reports over the past year and a half have proven that U.S. hospitals and health systems successfully went above and beyond to handle the crisis.

The most frequently cited changes to board/management structure or practices due to the pandemic include:

- Increased frequency of communication between the board and CEO/senior management/physician leaders (62%).
- Updated strategic and financial plans to address implications related to the pandemic (44%).

Our main takeaway from this part of the survey is that the pandemic has proven the ability of healthcare organizations to successfully implement rapid changes; however, when looking at the complete 2021 results and our overall observations of governance trends since 2001, boards and their organizations tend to make small, incremental changes in the right direction.

We believe that boards need to leverage the sense of urgency the pandemic created and work together with management to create bolder, more aggressive plans to move forward. Strategies involve expanding value-based care, improving quality and lowering costs, and, most importantly, addressing health disparities that can no longer be ignored.

Boards’ Performance in Management Oversight

Boards continue to do a “good” job overseeing CEO performance; however, this oversight area was ranked only fifth out of nine categories this year for overall performance. The least-adopted practice in this area continues to be maintaining a written, current CEO succession plan.

We are experiencing unprecedented global workforce shortages. Many CEOs retired during the past year, and the expectation is that many more will continue this trend due to burnout coupled with increasing operational challenges. We anticipate that talented CEOs will be more aggressively recruited.

It is imperative to ensure organizations have a current succession plan that includes “unplanned successions.” In addition, putting a leadership development program in place for internal talent can help protect organizations by building a continuous talent pool from which to draw as needed. Although it can be a difficult conversation to start, a strong board-CEO partnership in this effort enables the prioritization and alignment of these goals.

Executive Perspectives on Board Diversity and Community Benefit

This year’s report includes commentaries from two individuals with a chief executive lens: Kim A. Russel,
FACHE, a former healthcare CEO with over 30 years of experience in that role, who is now CEO of Russel Advisors, and Randy D. Oostra, DM, FACHE, president and CEO of ProMedica, Toledo, Ohio.

Russel focused her commentary on a broader view of board diversity, emphasizing the need for not only more women and ethnic minorities but also the need for more varied perspectives and backgrounds, including clinical. This year was the first time we saw any increase in ethnic minority representation on boards (62% of boards have at least one minority member, compared with 49% in 2019). A sizeable percentage of boards, however, still do not have any minority representation. The pandemic starkly reminded us of how important it is to cultivate a deep understanding of the needs of our communities, which is difficult to do without diverse voices at the table. Cultural and language barriers, along with mislaid assumptions, result in unintended consequences.

A diverse board can better help the organization fulfill its community health needs. The core responsibility of community benefit and advocacy typically hovers near the bottom of both the performance and adoption scales in our survey, and the 2021 results were no different from previous trends.

Oostra has focused on social determinants of health at ProMedica for many years, before the term gained widespread awareness. He urges healthcare organizations to step outside of their comfort zones to focus on how they can significantly impact health outcomes in their communities by addressing the root causes of health and well-being.

Russel reminds readers of the job of the governance/nominating committee in furthering these related efforts. Chief executives can help focus this committee’s goals and efforts. Most importantly, the chief executive is the public face of the organization as well as the chief fundraiser. Executives who are regularly out in their communities, meeting people from all walks of life, can also serve as effective recruitment engines, introducing the committee to potential board candidates who might have otherwise been overlooked or undiscovered.

A Team Approach to Improvement

Boards and their CEOs are on the precipice of challenge and opportunity. By building on the strengths of each other, they can journey outside the comfort zone of small, incremental change. The urgency created by the pandemic showed us all how to rapidly pivot. What would U.S. healthcare look like if every organization doubled down on addressing disparities? Focusing on board diversity, executive succession planning, and enhancing community benefit and advocacy efforts are three priority areas we believe boards and senior executives should have on their strategic agendas now.

Boards can engage management to better understand approaches to diversity, equity and inclusion. Here are just a few ideas to start with:

- Review your mission statement together and have a broader discussion about what the organization is and is not doing, and why.
- Dig into your board’s culture and how that affects the organization’s culture—is it one of true inclusion and empathy?
- Expand your organization’s definition of quality to include health equity, and add goals and metrics related to achieving a level of health equity that is acceptable to your community.
- Advance public health partnerships to help integrate activities and step in where there may be funding gaps.
- Craft a board recruitment strategy and executive succession plan that will provide stable leadership in this unstable time.

We hope that the lessons learned through the pandemic, which revealed how flexible, nimble, agile and swift healthcare organizations can be when the urgency requires it, can help boards progress more swiftly as well. We believe that healthcare delivery cannot be transformed unless the board itself is transformative.

Kathryn C. Peisert is managing editor of The Governance Institute, San Diego, Calif., and an ACHE Member (kpeisert@governanceinstitute.com).

Editor’s note: For more information about The Governance Institute’s 2021 Biennial Survey of Hospitals and Healthcare Systems, Advancing Governance for a New Future of Healthcare, please visit governanceinstitute.com/page/BiennialSurvey.
In recent years, many healthcare organizations have stepped up their cybersecurity efforts, but phishing scams and ransomware attacks have become more sophisticated. Healthcare remains a prime target for criminals. Cybercriminals have learned that healthcare organizations not only maintain large quantities of data but also will pay substantial sums of money to avoid an interruption in patient care and protect the safety of patients; other businesses can afford to close for longer periods of time since they do not have the same life safety concerns. To add to the complexity of the situation, the insurance industry has begun requiring more evidence-based ransomware prevention from organizations to avoid paying out when security is insufficient.

Healthcare’s recent digital expansion means cybercriminals have more targets. Telehealth, remote patient monitoring and patient-focused digital tools, such as mobile health tracking apps and patient portals, extend a health system’s digital landscape far beyond a physical campus. Typically, American healthcare IT systems are a complex integration of lab, medical, scheduling, accounting and EHR systems, using interfaced legacy and modern systems. Additionally, multiple vendors are involved with any healthcare organization, which only adds to the complexity. These challenges culminate in numerous entry points that need to be protected from cybercriminals.

A defining characteristic of an organization that establishes its human firewall is ardent buy-in from leadership.

The pandemic has also brought cybersecurity challenges to the forefront. More employees working off-site means information from across the organization is accessed from unvetted locations. This requires attention to how the remote workforce’s processing, access and storage of data is secured.

The complexity of this issue led to The Joint Commission’s decision to publish Quick Safety 62: Organization-wide Cybersecurity: Creating a Culture of Defense. The following actions can be taken to help organizations prepare for and repel a cybersecurity event:

Build your human firewall. A key takeaway of the publication is that cybersecurity can no longer be viewed only as the province of the IT department but must be the responsibility of all staff who have access to digital information, EHRs or network resources.

It cannot be overemphasized that organizations must build a culture of cybersecurity, also called the human firewall, in addition to their existing technical security programs. Basic cyber hygiene and patching will always be required. However, it only takes one person falling victim to a phishing scam to jeopardize the whole organization’s security posture, so the days of cybersecurity being solely IT’s responsibility are gone forever. This requires an awareness of cybersecurity threats, a continuous evaluation of existing threats and the incorporation of preventive strategies at all levels of the organization.

Gain senior leadership buy-in. A defining characteristic of an organization that establishes its human firewall is ardent buy-in from leadership. Effective senior leaders make sensitivity to cybersecurity threats and organizational preparedness part of the way the organization performs its work. An important step is supporting the chief information security officer’s promotion of cybersecurity programs. One program of importance is the development of a strong human firewall that achieves the following four objectives:
1. Identification of social engineering attempts to get confidential information or a user’s credentials. Does staff know how to identify a phishing email or text?
2. Rapid identification of a cyber event. Does staff know the signs of a cyberattack and how to report?
3. Rapid response to a cyber event. Does staff know how to contain a cyber event?
4. Continuous improvement. Is the program frequently reviewed and modified as needed?

Cybersecurity threats should be treated as a matter of when, not if. A strong human firewall requires an awareness of vulnerabilities and responses at all levels of the organization.

Establish staff training programs. With staff expected to take a greater role in cybersecurity, organizations would be remiss to neglect staff training. Training needs to include the entire workforce, not just clinicians. Every member of the organization needs to know that they are a critical part of an organization’s cyber defense and be educated to anticipate both conventional and nonconventional intrusions. These exercises should be tailored to different staff roles and the technology frequently used in each position.

To stay ahead of new threats, staff training cannot be a one-and-done event. Regular refreshers need to be part of the plan. Periodically evaluate staff to ascertain whether they appropriately respond to test cyber challenges such as phishing or social engineering tests. Based on the results of the testing, additional training should be conducted and the cycle repeated.

Testing should include how to identify and what to do in the event of a cyber security incident and not be limited to phishing tests.

Incorporate cyber emergency management. Responses to cybersecurity attacks need to be incorporated in other emergency plans. This includes having a clear link to business continuity and emergency management plans and ensuring staff can identify when a cyber incident should trigger the plan.

Any plan should include how to safeguard the greatest amount of data and information in a cyber event and who to notify if a potential breach occurs. In addition, operational contingencies need to be in place if a cyber event impacts some or all IT and biomedical systems. Staff can limit the impact of cyber events by thinking ahead and protecting critical backups from cybercriminals and making sure that offline emergency documentation is kept up to date.

Be mindful of staffing. Thinly spread staff and workforce burnout are growing issues as employees are asked to be more efficient and do more with the same or less. Overstretched and burnt-out staff make it challenging to maintain an effective human firewall because they are prone to making mistakes that affect security. Organizations, in recent years, have reduced headcounts to be as operationally efficient as possible. This limited staffing creates a challenge in how to prioritize daily operational responsibilities and strategic projects with important cyber initiatives and cyber responses. Staff try to balance these competing priorities themselves, which can result in burnout. Senior organizational leadership needs to be mindful of these challenges and collaborate with IT and business leadership to ensure that one does not suffer because of the other and either clearly reprioritize activities or bring in additional staff as needed. This will be easier for some organizations than others, especially in the current climate, where, even if there is a desire to bring in additional staff, many organizations are struggling with recruiting and maintaining their workforce.

As an alternative, in some cases, to hiring a consultant or bringing in additional IT staff, a wealth of free and trusted resources is available from government agencies and business partners. Some free resources that highlight best practices and include free cybersecurity tools include Cyber Insurance Carriers, Cybersecurity & Infrastructure Security Agency, Healthcare and Public Health Sector Coordinating Council, InfraGard, Internet Crime Complaint Center, National Institute of Standards and Technology, and SANS.

The Joint Commission is also always willing to share its winning practices. The Joint Commission will continue to post cybersecurity guidance and recommendations on its website for public use.

Criminals are smart and motivated, but as an industry, we can protect ourselves more effectively if we all work together. ▲

Patrick Ross is associate director, Federal Relations, The Joint Commission, Oak Brook, Ill. Michael DeGraff is director, Enterprise IT Security, The Joint Commission, Oak Brook, Ill.
Many of us in leadership positions are here to serve our communities. Striving for improved health outcomes and greater health equity, we carry these objectives as our driving force, day in and day out. We stay focused so we don’t get lost in the minutia. Through our work, we interact with community members, and it is always enlightening to hear comments about their delivery of care and any improvements that may be needed.

Through persistence, we have a successful hematology/oncology service offering care that improves the quality of life of our community and provides a culturally sensitive program.

More than three years ago, one of these interactions highlighted the vital need for cancer care in the Navajo Nation and started me on my journey to bringing cancer care to Tuba City (Ariz.) Regional Health Care Corporation—the first and only cancer clinic on any American Indian reservation.

A volunteer with the organization’s foundation, whom I had just seen and shared hellos with during a meeting, succumbed to cancer after being diagnosed only four to five months prior. I soon learned from her family the many barriers she faced to receiving cancer care. Transportation was one obstacle. She did not want her grown children to miss work and school to drive her 150 miles round trip to the nearest cancer center. Also, many of her family members did not have the money to make these trips. Weighing these factors, she decided not to get treatment.

The Case for the Cancer Center
Personally seeing the result of not having accessible cancer care, my executive team and I got to work looking at the presence of cancer in our community. In addition to no local access to cancer treatment and no reliable sources for assistance with cancer care, numerous other factors put the Navajo Nation at a higher risk for poor cancer outcomes and increased health disparities. These risk factors include lack of water and electricity, high poverty rates, environmental issues and, prior to our healthcare being managed by this tribal organization, poor access to primary care services.

On our executive team, which is made up of 11 Navajo tribal members who had grown up on the Navajo Nation, half had lost a primary relative to cancer. The need for accessible cancer care was obvious.

The Vision
To set the vision of providing cancer care at Tuba City (Ariz.) Regional Health Care Corporation, our team traveled to the Alaska Native Tribal Health Consortium in Anchorage, a consortium of 253 Alaska Native tribes, for input and inspiration. The health center had successfully launched a culturally sensitive program 10 years prior, and we learned about the program’s history and implementation tactics. This helped set the stage for developing our program to achieve health equity for our community.

The Preplanning
The first step to bringing cancer care services to the community was obtaining commitment from an oncologist team that would relocate and work for our organization.
Congratulations to our 2021 Thomas C. Dolan Executive Diversity Scholars

Aftab Ahmad, MD, FACHE
GME Program Director, Internal Medicine Residency Program
AdventHealth West Florida

Debbie DeMeo
COO, Houston District
Kindred Healthcare

CAPT Anthony Johnson, PhD
U.S. Public Health Service
Regional Behavioral Health Administrator

Ernesto Lopez
CEO
Hospice of Washington County

Patrick D. Lynch
Health Promotion and Disease Prevention Coordinator
Tsehootsooi Medical Center

Rani Morrison, FACHE
Chief Diversity and Community Health Equity Officer
University of Illinois Hospital

Stephen J. Mrozowski
Senior Director, Patient Safety & High Reliability
Cleveland Clinic

Chirag Patel, MD
Vice President Population Health
Centene Corporation

Latrice Prince-Wheeler, FACHE
COO, Medical Group
Providence Hospital (Providence Health System)

Pedro Rivera, FACHE
Regional Director, Labor Relations
NYC Health + Hospitals/Bellevue

Adrianne N. Wagner, FACHE
Regional Vice President, Quality and Patient Safety
Optum PNW (The Everett Clinic and The Polyclinic)

Applications for the 2022 EDP open March 8

Since 2014, the Thomas C. Dolan Executive Diversity Program has offered specialized leadership development for diverse leaders. EDP is designed for leaders in senior executive roles or those in C-suite positions who aspire to higher level or larger responsibility roles.
Once we had this team lined up, the executive team was one step closer to making cancer care a reality.

The second step, and a major hurdle on our journey, was determining the reimbursement model within the U.S. Indian Health Service all-inclusive payment system. We do not get paid fee-for-service; we receive a flat rate for outpatient care from Medicare and Medicaid. The cost-of-care process for American Indians involves state Medicaid programs paying providers for delivering care, called a “pass-through.” This means that they pay for the care and send the bill to the federal government. As most healthcare executives know, the costliest part of cancer care is the pharmaceuticals. We had many meetings with our state Medicaid program in which we asked for allowance for at least the reimbursed cost of medications, in addition to office visits, and the Medicaid director in Arizona eagerly made this amendment for us.

The next step was to get more data on the cancer care of American Indians. We quickly learned that very little information was readily available, particularly how exactly to plan these types of specialty care.

Our pivotal moment came in a meeting with the National Cancer Institute’s Cancer Moonshot Task Force at the White House. We met with a room full of cancer advocates, and we highlighted the lack of available cancer treatment on tribal land. Advocacy groups then assisted us in talking with the National Comprehensive Cancer Network and the Cancer Support Community, which provided us with a great deal of helpful information.

The Implementation

Next, I presented the data and findings to our healthcare organization’s governing board, and it approved the project to build a cancer program with capital funding. We worked with a successful cancer consultant and modeled the clinic with a replicable workflow that occurs in hematology/oncology clinics. We crafted job descriptions based on best practices and built a sustainable program with input from oncology experts.
The Opening
We publicized the opening within our tribal communities and state and national partners without the use of direct federal funds. The now-first lady Jill Biden, EdD, visited our program and helped us get additional publicity for the first cancer center on tribal land.

The first step to bringing cancer care services to the community was obtaining commitment from an oncologist team that would relocate and work for our organization.

Today, through persistence, we have a successful hematology/oncology service offering care that improves the quality of life of our community and provides a culturally sensitive program that welcomes and imparts kindness to our patients who have received a cancer diagnosis.

As I look back on this extremely challenging task, the takeaways include the importance of setting a vision for your team, working with each other’s strengths and keeping community needs in focus. As a CEO and leader, knowing I have impacted many lives gives self-gratification and purpose to this courageous career path I have chosen. Building on the positive impact of the cancer care offerings, Tuba City Regional Health Care Corporation will continue to improve health outcomes and strive to achieve health equity.

Lynette Bonar, RN, FACHE, is CEO of Tuba City (Ariz.) Regional Health Care Corporation (lynette.bonar@tchealth.org).

Editor’s note: Tuba City Regional Health Care Corporation, which is located about 78 miles north of Flagstaff, is the first and only cancer clinic on any territory belonging to American Indians, and Bonar is the first woman to lead a Navajo healthcare system. The program so far has had about 1,300 visits. The facility combines traditional healing with modern medicine, and staff, including Bonar, speak Navajo.

We look forward to welcoming you back to Chicago!

Join us March 28–31 at the Hyatt Regency Chicago to:
- Network with more than 4,000 healthcare leaders.
- Learn from more than 300 faculty experts in 130 sessions.
- Celebrate more than 600 new Fellows.
- Earn up to 18 ACHE Face-to-Face Education credits toward FACHE® advancement or recertification.

Visit ache.org/Congress for updated health and safety guidelines and registration information.
ACHE Call for Nominations for the 2023 Slate

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

- Nominating Committee Member, District 2 (two-year term ending in 2025)
- Nominating Committee Member, District 3 (two-year term ending in 2025)
- Nominating Committee Member, District 6 (two-year term ending in 2025)
- Four Governors (three-year terms ending in 2026)
- Chair-Elect

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

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

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

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

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

The first meeting of ACHE’s 2022–2023 Nominating Committee will be held March 29 during the 2022 Congress on Healthcare Leadership in Chicago. The committee will be in open session at 2:45 p.m. During the meeting, the Nominating Committee will conduct an orientation session for potential candidates 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 15 submission deadline, the committee will meet to determine which candidates for Chair-Elect and Governor will be

In Memoriam

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

**Scott R. Breunig, MD**
Pass Christian, Miss.

**Scott F. Madden, FACHE**
Ann Arbor, Mich.

**Francisco D. Sabichi, FACHE**
Denver

**William G. Sisson, FACHE**
Lexington, Ky.

**Mary Anne Weidner**
San Antonio

**Terry L. Varner**
Water Valley, Miss.
interviewed. All candidates will be notified in writing of the committee’s decision by Sept. 30, and candidates for Chair-Elect and Governor will be interviewed in person Oct. 27.

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

Thomas C. Dolan Executive Diversity Programs: Application Period Opens in Early March

The application period for the Thomas C. Dolan Executive Diversity and Career Accelerator Programs will be open from early March through mid-May. Both the Dolan EDP and CAP provide education, mentoring and networking experiences to prepare diverse leaders for higher-level positions in hospitals, health systems and other healthcare organizations. In 2022, the EDP program will consist of e-learning, including live and recorded webinars, self-study materials and three in-person sessions. The CAP will be exclusively virtual this year, consisting of 14 virtual live sessions. Dolan scholars are empowered through a structured curriculum and activities that cultivate strong leadership presence; sharpen expertise in diversity, equity and inclusion; build critical leadership skills; and expand one’s capacity to navigate career opportunities and challenges. Both programs are six months in duration.

The Dolan EDP has offered specialized leadership development for diverse leaders since it was established in 2014 by the Foundation of ACHE’s Fund for Healthcare Leadership to honor Thomas C. Dolan, who served as president and CEO of ACHE from 1991 to 2013. The program honors his long-standing service to the profession of healthcare leadership and furthers his strong commitment to achieving greater diversity among senior healthcare leaders. In 2021, the program was expanded with the addition of the CAP, designed for diverse mid-careerists to support their career advancement. For more information about the Executive Diversity and Career Accelerator Programs, visit ache.org/ExecutiveDiversity.

ACHE STAFF NEWS

2021 Pickert Award Winners Announced

Steve M. Harris, assistant director, applications, Department of Information Technology, and Belinda Roman, program coordinator, Career Resource Center, Department of Executive Engagement, are the 2021 winners of the Alton E. Pickert Award, which recognizes employees who have demonstrated significant service to ACHE and its members.

The award was established by Anne M. Pickert to honor the memory of Alton E. Pickert, FACHE, ACHE Chair from 1983 to 1984. During his tenure, Pickert emphasized the important contributions of ACHE staff to the healthcare leadership field. Harris joined ACHE in 2019. Roman joined ACHE in 2011.

ACHE Staff Members Give Back to Community in 2021

In 2021, ACHE’s staff members gave generously during the annual United Way of Metropolitan Chicago pledge drive. The team donated more than $8,200 for United Way of Metropolitan Chicago. When combined with a $3,000 donation from ACHE, the amount raised totaled over $11,200.

ACHE Announces New Hire, Promotion

Following are new hire and promotion announcements.

Margarita G. Granados welcomed as events coordinator, Professional Development, Department of Learning.

Mary F. Howorth promoted to events coordinator, Professional Development, Department of Learning, from customer service representative, Department of Executive Engagement.
Personnel shortages ranked No. 1 on the list of hospital CEOs’ top concerns in 2021, replacing financial concerns—the top issue since 2004, according to ACHE’s annual survey of top issues confronting hospitals. This survey, sent in the fall to community hospital CEOs who are ACHE members, asked respondents to rank 11 issues affecting their hospitals in order of how pressing they are, and to identify specific concerns within each of those issues. The survey was sent to 1,327 community hospital CEOs, of whom 310, or 23%, responded. This year, respondents cited personnel shortages as their top concern, giving it an average rank of 1.6 on an 11-point scale, underscoring the workforce challenges seen during the pandemic. Financial challenges ranked second, with an average rank of 4.1. Patient safety and quality ranked third, with an average rank of 5.0.

ACHE thanks the CEOs who responded for their time, consideration, and service to their profession and to healthcare leadership research.

### Specific Concerns Within the Top Issues

Within each of these 11 issues, respondents identified specific concerns facing their hospitals. Following are those concerns in order of mention for the top three issues identified in the survey. (Respondents could check as many as desired.)

#### Personnel Shortages (n = 310)
- Registered nurses: 94%
- Technicians (e.g., medical technicians, lab technicians): 85%
- Therapists (e.g., physical therapists, respiratory therapists): 67%
- Primary care physicians: 45%
- Physician specialists: 43%
- Physician extenders and specially certified nurses (physician assistants, nurse practitioners, certified nurse midwives, etc.): 31%
- Other: 17%

#### Financial challenges (n = 310)
- Increasing costs for staff, supplies, etc.: 87%
- Reducing operating costs: 53%
- Medicaid reimbursement (including adequacy and timeliness of payment, etc.): 52%
- Managed care and other commercial insurance payments: 44%
- Bad debt (including uncollectable) (Emergency Department and other charges): 39%
- Competition from other providers (of any type—inpatient, outpatient, ambulatory care, diagnostic, retail, etc.): 39%
- Government funding cuts (other than reduced reimbursement for Medicaid or Medicare): 39%
- Medicare reimbursement (including adequacy and timeliness of payment, etc.): 39%
- Transition from volume to value: 39%
- Inadequate funding for capital improvements: 35%
- Revenue cycle management (converting charges to cash): 32%
- Pricing and price transparency: 27%
- Emergency Department overuse: 26%
- Moving away from fee-for-service: 25%
- Other: n = 11

#### Results by ACHE’s Executive Office, Research.

Personnel shortages ranked No. 1 on the list of hospital CEOs’ top concerns in 2021, replacing financial concerns—the top issue since 2004, according to ACHE’s annual survey of top issues confronting hospitals. This survey, sent in the fall to community hospital CEOs who are ACHE members, asked respondents to rank 11 issues affecting their hospitals in order of how pressing they are, and to identify specific concerns within each of those issues. The survey was sent to 1,327 community hospital CEOs, of whom 310, or 23%, responded. This year, respondents cited personnel shortages as their top concern, giving it an average rank of 1.6 on an 11-point scale, underscoring the workforce challenges seen during the pandemic. Financial challenges ranked second, with an average rank of 4.1. Patient safety and quality ranked third, with an average rank of 5.0.
Thank You to Our Premier Corporate Partners

ACHE is fortunate to have some of the field’s leading companies share in our mission of advancing healthcare leadership excellence. Our Premier Corporate Partners play an important role in strengthening the healthcare leadership profession and in building healthy communities.

By partnering with us, these companies demonstrate a real commitment to career development and lifelong learning. Please join me in expressing thanks to our Premier Corporate Partners for all they do in support of our mission.

Deborah J. Bowen, FACHE, CAE
President/CEO
American College of Healthcare Executives
Financials Approved

The Board received the financial statements for the nine-month period ending Sept. 30, 2021. The financial performance reflects strong growth in membership, members advancing to Fellow and education programming virtual attendance. Membership growth, with the current count of Members/Fellows, is up 3% year-to-date over 2020. Fellow applications are up over 300% from both 2020 and 2019 due to a change in membership tenure and pent-up demand. Education participation was equally strong, with nearly 100,000 credits earned, largely due to the success of the 2021 virtual Congress on Healthcare Leadership.

With strong support from Regents, chapters and members, the Board approved the 2022 proposed budget and work plan for ACHE and the Foundation of ACHE. Steady membership growth is expected through targeted marketing campaigns and promotion of online resources. Significant growth from 2021 is anticipated in education related to planned expansion of face-to-face events and virtual online products. The Board also noted it will need to monitor performance, given the uncertainty of the current climate.

2022–2024 Strategic Plan

The Board unanimously approved the 2022–2024 Strategic Plan, which includes a bold set of ambitions to leverage our roles as catalyst, connector and trusted partner during the next three years: as a Catalyst, to achieve our highest calling to advance health by leading through the lens of equity; as a Connector, to grow our professional community of leaders across the healthcare continuum by leveraging our partnerships with chapters and other organizations; and as a Trusted Partner, to provide resources to help leaders reach their highest potential to lead. Specific goals will be developed to monitor our progress.

The Board also discussed the investments required in technology and other high-level priorities, such as diversity, equity and inclusion, to ensure effective execution of the plan.

2022 Congress on Healthcare Leadership Update

The Board received an update on Congress as it pertains to the pandemic and new offerings. Safety will be the No. 1 priority for attendees during the in-person event March 28–31. ACHE will follow guidelines from the Centers for Disease Control and Prevention, state of Illinois and city of Chicago to ensure a safe learning environment. Proof of COVID-19 vaccinations will be required for attendance at an in-person event.

The Board was also given an overview of what to expect regarding programming, including new offerings such as an updated Solutions Center with expanded career services, and a CEO all-access pass and targeted CEO education.

In addition, the Board was updated on the Virtual Leadership Symposium that will be held April 11–12. The virtual format allows for members to receive ACHE Face-to-Face Education credit should any of our plans need to change.

Education Update

The Board reviewed plans to resume in-person events with a multiyear approach for virtual and in-person education, the establishment of regional clusters with seminars and special programs, and expansion of the Executive Program, which will include virtual and in-person sessions with executive, senior executive, physician and global executive cohorts. In addition, the Board was provided an update on the Board of Governors Exam Review course. It will continue to be offered only virtually in 2022, with plans to refresh the curriculum and course design.

International Update

The Board was provided an update on the International Hospital Federation, where leaders played key roles. ACHE President/CEO Deborah J. Bowen, FACHE, CAE, was appointed president during its 44th World Hospital Congress in Barcelona, Spain, Nov. 8–11 and will serve a two-year term. Bowen presented the opening plenary session titled “Women Leadership: Agility, Responsiveness and Resilience in Combating COVID-19.” The Board was also briefed on other key sessions, including “North American Leadership Insights: Leading During Times of Crisis,”
During which ACHE Chair Carrie Owen Plietz, FACHE, and ACHE Immediate Past Chair Michael J. Fosina, FACHE, served as panelists, along with Melinda Estes, MD, president and CEO, Saint Luke’s Health System. Richard Pollack, president and CEO, American Hospital Association, moderated the session.

In addition, the Board was informed of IHF Award winners, which included ACHE’s Excellence Award for Leadership and Management that can be found in the Jan/Feb 2022 issue of Healthcare Executive in “Executive News.”

**ACHE Code of Ethics and Policy Statements Updated**

The Board of Governors approved changes to two existing ACHE Policy Statements, four Ethical Policy Statements and the Code of Ethics suggested by relevant ACHE committees and subject matter experts to the Board Policy Committee. The committee revised statements to reflect updates to data, terminology and language; to incorporate contemporary solutions and current, real-life healthcare leadership experience; and to clarify ACHE’s position in certain policy positions and to ensure they reflect ACHE’s values. The following statements were updated:

- “Access to Affordable Healthcare.”
- “Considerations for Healthcare Executive-Supplier Interactions.”
- “Ethical Decision-Making for Healthcare Executives.”
- “Health Information Confidentiality.”
- “Healthcare Executives’ Responsibility to Their Communities.”
- “Promise Making, Keeping and Rescinding.”

A revised *Code of Ethics* can be found at [ache.org/EthicsPolicyStatements](http://ache.org/EthicsPolicyStatements). All Policy and Ethical Policy Statements can be found at [ache.org/PolicyStatements](http://ache.org/PolicyStatements).

Next Meeting Planned

The Board of Governors is scheduled to meet March 25, 2022, preceding the Congress on Healthcare Leadership in Chicago. Highlights of that meeting will be published in a future issue of Healthcare Executive.

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**Future Healthcare Executives**

With a wide range of career opportunities and challenges, you already know how dynamic the field of healthcare has become. Spread the word about the healthcare management profession today.

Support the Future of Healthcare Management

Visit [HealthManagementCareers.org](http://HealthManagementCareers.org) to find ACHE’s resource guide for students looking for a better understanding of the rewarding profession of healthcare management.
Rita Bunch, FACHE, to president, Sentara Martha Jefferson Hospital, Charlottesville, Va., from vice president, operations, Sentara RMH Medical Center, Harrisonburg, Va.

Luis A. Castro to COO, El Centro (Calif.) Regional Medical Center, from chief human resources officer.

Troy B. Chisolm, FACHE, to COO, Vanderbilt Psychiatric Hospital, Nashville, Tenn., from CEO, Pinewood Springs, Columbia, Tenn.

Barbara Perez Deppman, RDMS, FACHE, to COO, Strategic Radiology, Dallas-Fort Worth. Deppman served as executive director, Radiology Associates of South Florida, Miami, from 2015 to 2018.

Shawn Ekwall, FACHE, to COO, IGEA Brain Spine & Orthopedics, Union, N.J., from regional manager, RWJ Barnabas—Rutgers Combined Medical Group, West Orange, N.J.

Cindy A. Elliott, RN, FACHE, to president, IHA Medical Group, Ann Arbor, Mich., from president and COO.

Thomas J. Hathaway Jr. to vice president, operations, Holy Cross Medical Group, Fort Lauderdale, Fla., from executive director, orthopedics and sports medicine, Holy Cross Health.

Randy K. Hawkins, MD, FACHE, to CMO, Carrum Health, San Mateo, Calif., from CMO/executive vice president, health analytics, ConsumerMedical (acquired by Alight), Pembroke, Mass.

Thomas M. Klein, FACHE, to COO, Ascension Medical Group Michigan, Warren, Mich., from vice president, oncology service line.

Jessica R. O’Neal, FACHE, to CEO, Medical City Las Colinas, Irving, Texas, from CEO, Medical City Children’s Hospital and Medical City Women’s Hospital, Dallas.

Andy Poole, FACHE, to ASC business solutions manager, ECRI, Plymouth Meeting, Pa., from CEO, Monticello Community Surgery Center, Charlottesville, Va.

Scott Raynes to president/CEO, Southeast Georgia Health System, Brunswick, Ga., from president, Baptist Hospitals Inc., Pensacola, Fla.

David J. Reisman, FACHE, to vice president, Emergency Preparedness and Business Continuity, Massachusetts General Brigham, Boston, from executive director, Emergency Preparedness, and senior administrative director, Emergency Medicine, Massachusetts General Hospital, Boston.

Stephanie B. Schwartz, FACHE, to president, Overlook Medical Center, Summit, N.J., from interim president.

Janet Stanek, FACHE, to secretary, Kansas Department of Health and Environment, Topeka, Kan., from director, State Employee Health Benefits Program, Kansas Department of Administration.

Nichole C. Wilson, DPT, FACHE, to vice president, community health operations, Indiana University Health, from vice president, integrated primary care, Community Health Network, both in Indianapolis.

David E. Womack, LFACHE, to retirement from senior vice president, Kaiser Permanente, Bakersfield, Calif. We would like to thank David for his many years of service to the healthcare field.

This column is made possible in part by Exact Sciences.
The Time Is Now to Nominate a Colleague

Gold Medal Award
The Gold Medal Award is the highest honor bestowed by the American College of Healthcare Executives on outstanding Fellows who have made significant contributions to the healthcare profession. Deadline: Aug. 16, 2022
ache.org/GoldMedal

Lifetime Service and Achievement Award
The Lifetime Service and Achievement Award was created to recognize Life Fellows and Retired Fellows who have made outstanding, nationally recognized contributions to advance the profession of healthcare management and the American College of Healthcare Executives. Deadline: July 16, 2022
ache.org/LifetimeService

Robert S. Hudgens Memorial Award
The Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year was established to recognize early careerists for outstanding achievements in the field of healthcare management. Deadline: July 16, 2022
ache.org/Hudgens

If you have any questions about the awards, contact Jennifer L. Connelly, FACHE, CAE, in the Department of Regional Services at (312) 424-9320 or via email at jconnelly@ache.org.
As one of ACHE’s four core values, diversity and inclusion is integral to ACHE’s mission and daily work, and we are committed to creating a more diverse healthcare leadership. Our chapters have been helping to demonstrate this commitment through numerous programs and initiatives.

Recognizing Chapter Accomplishments in Diversity
Each year, Regents-at-Large recognize chapters that actively demonstrate a commitment to and successful implementation of significant diversity and inclusion efforts within the chapter, community and the healthcare management field. The following chapters were recipients of the 2021 Regent-at-Large Awards, which were given during the annual Chapter Leaders Conference in October.

CT Association of Healthcare Executives
During the past two years, the CT Association of Healthcare Executives saw the challenges of the pandemic as an opportunity to strengthen its engagement with the communities it serves and to offer its members strategies for improving diversity, inclusion and equity efforts.

The chapter held discussions with local experts in public health, healthcare leadership and diversity to come up with ideas for dealing with the pandemic, and it conducted a DEI climate survey to measure its progress in diversifying its membership and examine opportunities for improvement. One idea was to launch a video series to promote the value of ACHE membership and chapter engagement. Leaders in the video series shared how the chapter has helped their professional growth and how it fosters diversity among its members. The chapter’s DEI efforts continue to evolve to meet the ever-changing nature of the challenges faced by healthcare leaders.

The Washington State Healthcare Executives Forum established DEI-specific goals for 2021, which expanded on its commitment to diversity, equity and inclusion.

American College of Healthcare Executives of Central Florida
The American College of Healthcare Executives of Central Florida embraces and embodies diversity and inclusion, which translates into increased engagement of diverse members. This includes reviewing the chapter’s board and membership demographics and taking steps to promote diversity, such as having a diversity and inclusion chair and an award and events with a diversity focus. For example, the chapter’s annual Diversity and Inclusion Award recognizes a healthcare leader within the chapter area who has demonstrated consistent efforts to increase diversity within healthcare management.

The American College of Healthcare Executives of Central Florida also creates programs and content that reflect its diverse membership. For example, it offered sessions on gender equity and held a symposium on women in healthcare leadership that covered women’s health and the challenges posed by COVID-19. Other educational events included topics on leadership in changing times, diversity in the workforce and racial disparities in healthcare.

ACHE of Greater Ohio
ACHE of Greater Ohio has committed to ensuring diversity, equity and inclusion in the chapter and its leadership. Initiatives include creating a spotlight section for its website, where every six weeks the chapter highlights a different ACHE of Greater Ohio board member or officer to demonstrate the diversity of its board. The chapter also promotes diversity, equity and inclusion as much as possible on its Twitter and LinkedIn channels. For example, it recognized Pride Month the past two years by featuring a statement of support for the event on the chapter’s website and social media. Additionally, the chapter has held events that have focused on topics such as equity of care, diversity in the workforce and women in healthcare leadership.

The chapter has also collaborated with the National Association of Health Services Executives in several ways. For example, a member of the Cincinnati NAHSE chapter has sat...
on the board and diversity committee of the ACHE of Greater Ohio board. Furthermore, there is representation from the Cincinnati NAHSE chapter and the ACHE of Greater Ohio chapter on the local program councils for Cincinnati and Columbus. The chapter also collaborated with NAHSE on an equity of care event.

**South Texas Chapter of the American College of Healthcare Executives**
The South Texas Chapter of the American College of Healthcare Executives is addressing and raising awareness about issues of equity, diversity and inclusion within the chapter and community. These efforts included chapter leader outreach to chapter members to ensure the chapter is providing educational and social opportunities focused on diversity and inclusion.

Various chapter committees also worked together to ensure events had DEI representation in terms of speakers and content and that all members were invited to these events. The Diversity Committee also added more articles to the chapter’s newsletter, highlighting members’ accomplishments in the community through interviews.

The chapter also partnered with local organizations on DEI-focused efforts. For example, it collaborated with the San Antonio AIDS Foundation on a COVID-19 outreach program to provide vaccines to at-risk populations in the greater San Antonio area. The chapter provided marketing collateral for the program in both English and Spanish and helped with directing patient flow and translating for Spanish-speaking people. Additionally, it partnered with a local nursing association to increase the reach of its efforts to support DEI, and it held a volunteer event with a local homeless assistance organization to enhance the equity of facility upkeep and cleanliness for all people across South Texas.

**The American College of Healthcare Executives of Central Florida embraces and embodies diversity and inclusion, which translates into increased engagement of diverse members.**

**Washington State Healthcare Executives Forum**
The Washington State Healthcare Executives Forum established DEI-specific goals for 2021, which expanded on its commitment to diversity, equity and inclusion. These goals focused on increasing DEI programming events and building relationships with community partners.

For example, the chapter’s Programs Committee has taken steps to ensure it is more inclusive of and collaborative with other committees and groups when developing its educational events. Also, the chapter designed and hosted statewide virtual diversity meet and mingle events.

To foster community partnerships, Washington State Healthcare Executives Forum created a liaison role for the National Association of Health Services Executives and National Association of Latino Healthcare Executives. Additionally, the chapter included a DEI-focused article in its newsletter, and it plans to create a DEI-focused space on the chapter website and develop a DEI award that recognizes the efforts of individuals within the chapter.

For more information and resources regarding ACHE’s diversity, equity and inclusion efforts, please visit [ache.org/DiversityandInclusion](http://ache.org/DiversityandInclusion).

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

Approved by the Board of Governors Dec. 6, 2021.

Statement of the Issue
The healthcare executive’s responsibility to the community is multifaceted. It encompasses a commitment to increasing access to needed care, improving community health status, and addressing the societal issues that contribute to poor health and health disparities, as well as personally working for the betterment of the community at large. It includes a commitment to eliminating disparities in care, creating trust between the organization and the community and supporting the well-being of caregivers. Taking a leadership role in serving the community is the responsibility of all healthcare executives regardless of occupational setting or ownership structure. When providers, individuals and communities work toward common goals, the results can be significant: healthier children, healthier adults, healthier caregivers, reduced healthcare costs, appropriate use of limited healthcare resources and, ultimately, a healthier community.

Policy Position
The American College of Healthcare Executives believes all healthcare executives have a professional obligation to serve their communities through support of organizational initiatives and personal involvement in community and civic affairs. In addition, ACHE believes healthcare executives should take a proactive role in individual and community health improvement efforts. ACHE recognizes communities vary widely in demographic characteristics, resources, traditions and needs. Therefore, each community may have different priorities and approaches.

Healthcare executives can lead or participate in community and organizational initiatives through the following actions:

- Actively engage in collaborative efforts with public health and other government agencies, healthcare systems and organizations, businesses, associations, educational groups, religious organizations, elected officials, financing entities, foundations, and others to measure and assess the community’s health status, including the most prevalent health and social issues and concerns, underlying causes, associated risk factors, and the diversity of available resources that may be applied to improve the community’s well-being.

- Support efforts to eliminate health disparities for vulnerable populations, including reducing barriers to access; supporting programs that address adequate housing and food supply; increasing the supply of health workers and other resources in underserved communities; systematically collecting race, ethnicity and language preference data of your patients; and training to help healthcare providers deliver culturally competent care.

- Have a program of outreach to ensure that community needs are considered in the strategic planning and resource allocation of the organization.

- Support the dissemination of accurate information about community health status, the services provided and programs available to prevent and treat illness, and patients’ responsibility for their own health.
• Participate in efforts to communicate organizational effectiveness in matching healthcare resources with community needs, improved clinical outcomes and community health status, and their organization’s involvement in volunteer activities.

• Incorporate community service responsibilities into policies and programs over which they have authority.

• Encourage and support staff members in personally demonstrating their commitment to the community.

• Demonstrate that their commitment to the community is multifaceted and may include training of healthcare professionals, approaches to reducing the cost of care for those in need (such as free or reduced-cost care or sliding scales), civic contributions and supporting medical research, as well as a host of other activities that contribute to the community’s well-being beyond that of their own organization.

• Invest in the community by providing employment opportunities to community members.

• Offer health promotion and illness prevention programs to their employees, positively benefiting staff as well as sending an important message to the community.

Healthcare executives can personally demonstrate their commitment to the community through the following actions:

• ACHE members should model behavior they are advocating for their employees and the community at large. Appropriate behavior may include exercising regularly, refraining from smoking, adopting a healthy diet, taking steps to reduce stress and getting preventive checkups to address health problems before they become serious.

• Participate in local assessments of community need.

• Be the catalyst for community-based interventions.

• Participate in regional, state and local task forces to resolve health disparities and other community healthcare problems.

• Actively advocate for the community with the public, policymakers and other key stakeholders to define community healthcare priorities so that healthcare resources can be used equitably and effectively.

• Become involved in community service projects, civic organizations and public dialogue on healthcare policy issues affecting the community.

• Share models of successful healthy community projects with others to enhance efforts in other communities.

ACHE urges all healthcare executives to affirm their responsibility to their communities through their professional actions and personal contributions. To further strengthen its position on community responsibility, ACHE requires its members to produce evidence of participation and leadership in healthcare and community/civic affairs to advance within ACHE.
Three Leadership “Levers” That Help Executives Get More Done and Achieve Better Results

Healthcare executives today are expected to achieve significant progress on a wide range of goals. For many, this means managing a large portfolio of clinical, financial and strategic initiatives.

Unfortunately, many healthcare leaders struggle with managing multiple projects at the same time. The solution is mastering three leadership “levers.”

1. **Top-Down Strategic Alignment**

The heart of every successful initiative is a strategic vision for improving performance. Many initiatives, however, fail because they are not aligned with the organization’s true strategic priorities.

For example, a surgical services director launches an initiative to expand same-day surgery in the hospital OR; however, the C-suite strategy is to increase quality and reduce costs by shifting same-day procedures to ambulatory surgery centers and focusing the inpatient OR on complex, high-revenue surgical service lines. Sooner or later, the director’s same-day surgery initiative will collide with this strategic obstacle.

To leverage top-down alignment, the OR director could focus instead on reducing clinical variation in complex inpatient surgeries. Success here would improve quality, outcomes and profitability in the procedures that are becoming the heart of inpatient strategy.

2. **Bottom-Up Change Management**

Another reason healthcare projects fail is that they do not have the support of the individuals impacted by the initiative. Effective leaders know how to propel initiatives forward by creating and leveraging “bottom-up” support. Three steps are key:

- **Identify the “burning platform”:** Begin by working with stakeholders to articulate the problems with the status quo.

- **Articulate the future vision:** The ideal vision helps everyone see and understand how an initiative will change both their work and the outcomes they achieve.

- **Fill in the activation plan:** Start with a high-level timeline showing key milestones, and then work with project managers and select stakeholders to fill in the details of execution and gain leadership approval.

3. **End-to-End Measurement**

Most healthcare leaders know the aphorism “You only get what you measure.” To increase your initiative’s probability of success, consider the following:

- Establish both process metrics (such as percent project completion) and outcome metrics (for instance, percent reduction in direct costs).

- Determine the data sources for each metric as well as the frequency of reporting progress against goals.

- Regularly communicate results to all providers and staff impacted by the initiative.

The best way to leverage end-to-end measurement is to create a performance scorecard that highlights key metrics and goals and tracks individual and group progress.

**Rising to the Occasion**

By mastering the skills of top-down strategic alignment, bottom-up change management and end-to-end measurement, healthcare executives can both increase their personal effectiveness and improve their organizational results.

*Source: From an article by John Malone, principal (jmalone@luminahp.com), and Steven Berger, LFACHE, FHRMA, principal (sberger@luminahp.com), Lumina Health Partners, Chicago.*

**Editor’s note:** An expanded version of this article with additional examples is available at HealthcareExecutive.org.
We show up
for our patients for our communities for each other

Visit HCA Healthcare’s Executive Recruiting Suite at the 2022 ACHE Congress in Chicago

Swissotel Chicago
St. Gallen III, 2nd floor

Monday, March 28 (7:30 a.m. – 2 p.m.)
Tuesday, March 29 (7:30 a.m. – 2 p.m.)
Wednesday, March 30 (7:30 a.m. – 12 p.m.)

Make plans to attend the following speaking engagements with HCA Healthcare leaders:

Leadership Insights: Healthcare System of the Future
Featuring HCA Healthcare CEO, Sam Hazen
Monday, March 28
Hyatt Regency
2 – 3 p.m. (CST)

The Continuum of Care: Evolution of Behavioral Health Services
Featuring Eric Paul, President of Behavioral Health Services
Tuesday, March 29
Swissotel Chicago
St. Gallen III, 2nd floor
2:30 – 3:15 p.m. (CST)

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