

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

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Helping Great Physicians
Become Great Leaders

LOOKING BACK *TO MOVE FORWARD*

How Past Tech Results Are
Helping Healthcare Leaders
Focus on the Future



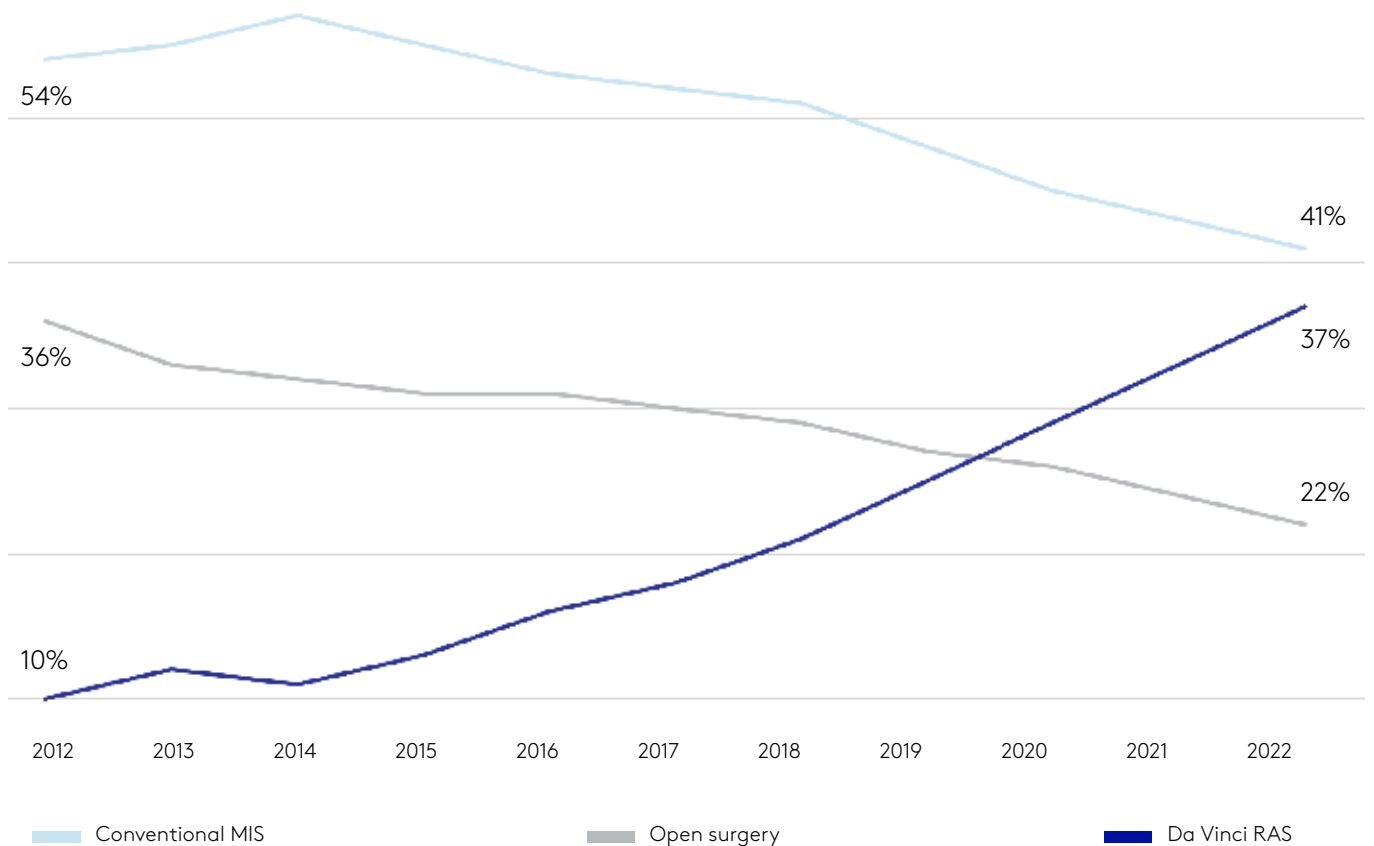
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Cover Story

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To chart a clear path for a smooth system rollout, experts say to look back and revisit lessons learned from past implementation as an integral part of the process.

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Bolstering meaningful patient engagement is among the top goals and connected uses for technology that health systems are implementing.

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The Strategic Rise of the Supply Chain

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A Digital-First Approach to Care Redesign

Read how UCSF Health’s Center for Digital Health Innovation creates, tests and implements various digital technologies in clinical environments, using a multidisciplinary team with expertise in digital technologies, clinical informatics, user-centered design and data science.



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In “A Conversation With Delvecchio S. Finley, FACHE, ACHE’s 2023–2024 Chair,” **Finley**, president, Atrium Health Navicent, Macon, Ga., and ACHE’s Chair, shares his career journey, gives advice to emerging healthcare leaders and discusses the issues he is committed to addressing during his term as Chair.

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Randy F. Liss

Keeping Pace With Tech's Expansion

Generative AI just might be the story of 2023, as experts weigh the potential benefits this technology can provide—and the havoc it could wreak. Despite all the headlines, it's still just one piece of the larger global tech market, which on the healthcare side is expected to grow from \$439 billion this year to a whopping \$852 billion by 2027.

That makes this a fitting time to see how healthcare leaders are preparing for what's coming, and many are doing so by learning from the past. In our cover story, "Looking Back to Move Forward: How Past Tech Results Are Helping Healthcare Leaders Focus on the Future," healthcare leaders we've previously spoken with about technology implementation share the ways in which they're applying lessons learned to their tech pursuits of today. "We are always experimenting," one leader says, "but we learn fast." That's a good approach given the speed at which technology is moving today.

Our second feature, "Using Technology to Inspire Patient Engagement," looks at how hospitals and health systems are leaning on innovations to keep patients not only healthy but happy. From a virtual nursing program that interacts directly with patients to a portal that provides patients and their family members access to medical images and videos, technology is offering more ways to make patients part of the care process. As one healthcare leader tells us, "When patients are more involved, they are happier with their care and their health improves. It's a win-win."

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

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Deborah J. Bowen,
FACHE, CAE

Building a Culture of Cross-discipline Collaboration

Fostering this can reap benefits for all.

Despite the challenges in healthcare one constant remains: We all care deeply about doing our best for patients. Regardless of the circumstances and conditions, this is our true north. In the foreground of healthcare delivery today, we know that driving to equity, combined with workforce shortages and a growing population with chronic disease and other complexities, will require new approaches and solutions. Progress here will require more of our individual and collective skills, perseverance and passion to make headway.

Studies also show that collaborative approaches in care can drive coordination and efficiency that lead to reduced medical errors and improved outcomes. In some hospitals and health systems, dyad leadership has reaped benefits, as has the concept of triads: administrators, physicians and nurses working together. Lessons from these arenas can help us shape how we work, while also expanding the benefit of the richness of our varied disciplines present in caring for patients.

While not new, the current stakes and imperatives suggest that as leaders, building the culture of “and” will reap greater benefits for all. In formal clinical partnerships, there is, of course, a process to making this work, including identifying the right talent and

preparing them to take on high-level leadership roles. Communication, conflict resolution and trust-building are just a few of the necessary skills, as are an ability and willingness to embrace shared decision-making to encourage open mindedness, among many others.

Beyond formal roles, there is also a benefit to ensure cross-discipline collaboration in problem-solving and managing patient care. Informally there are plenty of ways to foster a culture where collaboration rules. Expanding the participants in rounding, having open floor plans, taking part in tech-based collaborations, tackling troublesome problems and offering more structured team training have all been cited as useful techniques. Simple acts of collaboration across the clinical and administrative spectrum can lead to powerful results. To gain the benefit here, support from senior leaders must be evident, including clarifying the importance of cross-discipline teaming. Opportunities to learn and grow have also been shown to enhance engagement and satisfaction.

For our part, ACHE can serve as a connective tissue between clinical and nonclinical partnerships to develop leaders. As a strategic initiative, ACHE has intentionally built partnerships

with other clinically based associations to bring together leaders and experts through education and networking. This has led to clinicians, learning side by side with us, learning the competencies of working effectively as part of a highly functioning team.

Interprofessional education is an important aspect of the ACHE experience, and opportunities are growing. Our partnerships with the American Society of Anesthesiologists and the American Physical Therapy Association have delivered educational programs focusing on clinical leadership for those specialties. Work with the American Academy of Physician Assistants has resulted in a joint leadership development program to help physician assistants migrate from individual contributor roles as clinicians into department and team leaders. And the American Society of Health System Pharmacists has partnered with us to develop programming to grow the number of hospital and health-system pharmacists serving in high-level executive positions, including CEO and COO.

Collectively these partnerships, and clinicians’ individual participation, offer a deeper understanding of the critical roles that clinical and non-clinical teams can play in care delivery together. They also offer us a reminder that by expanding our expertise and perspective, we are able to advance our learning and make progress in equity and quality of care to realize the positive outcomes our patients deserve. ▲

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

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LOOKING BACK *TO MOVE FORWARD*

How Past Tech Results Are
Helping Healthcare Leaders
Focus on the Future

By Susan Birk



TO grasp the speed of evolution in healthcare digital technology, consider: The healthcare artificial intelligence market is projected to grow to \$188 billion by 2030 at a compound annual growth rate of 37% from \$11 billion in 2022, according to data provider Statista.

Ninety percent of hospitals now have an AI strategy in place, a survey by advisory firm Sage Growth Partners found. With 100 million users within a week of its launch in November 2022, Open AI's ChatGPT has also fueled AI's adoption in the healthcare sector.

More broadly, the global healthcare technology market is expected to grow 18.3% to \$439 billion in 2023 from \$371 billion in 2022, and projections indicate the market will have nearly doubled to \$852 billion by 2027, according to ResearchAndMarkets.com's *Healthcare Technology Global Market Report 2023*.

Though these numbers paint an impressive picture of healthcare IT, organizations don't really need them to know how fast healthcare digital technology is moving. They experience it in the influx of product introductions and upgrades vying for their attention every day.

Learn From Past Misses

Digital technology's potential to improve quality, streamline processes and democratize care is breathtaking, but the velocity of the change can unnerve even the most intrepid. Indeed, "figuring out how to develop systems to use a growing quantity and variety of digital information is perhaps the most important, and formidable, health care mission of our time," leaders of the National Committee for Quality Assurance write in *Harvard Business Review*.

LOOKING BACK TO MOVE FORWARD

A potential pitfall is becoming confused and distracted by all the newness. To chart a clear path for a smooth system rollout, experts encourage providers to look back and revisit lessons learned from past implementation as an integral part of the process. Learning from earlier mistakes—and successes—can be a powerful antidote to the market's flood of shiny new objects and an anchor for smart planning rooted in problem-solving.

“Adding a lot of gadgets to an existing clinic that already has its fair share of existing tech only complicates the ‘system’ rather than making it simpler,” writes business adviser Heath Gascoigne, London.

It behooves providers to understand where they've erred previously so they can avoid repeating the same mistakes down the road.

Don't Be Afraid

“It's about a balance between staying in touch with the market and understanding where things are going on the one hand, and ‘keeping the lights on’ and maintaining what we already have on the other, all while thinking about innovation that will move the needle in terms of quality and efficiency,” says Jeffrey Sturman, senior vice president and chief digital officer at Memorial Healthcare System, Hollywood, Fla. Sturman is an ACHE Member.

That balancing act incorporates reflection on past successes and misses, he notes. When the COVID-19 pandemic hit, Memorial Healthcare System quickly deployed an electronic solution to monitor hand-washing compliance due to heightened infection control concerns. But “because we moved so quickly, we implemented a

technology that wasn't ready for broad deployment, and we eventually had to remove it. We were dealing with the here and now of the pandemic, so our due diligence wasn't what it should've been,” he says. Lessons learned from that experience, including the importance of evalu-

ating all the options, even during a crisis, will inform the system's next implementation of a hand-washing compliance tool.

Still, considering how rapidly digital technology is progressing, Sturman contends that “it's important not to be afraid to try things. There's no harm if you have a culture of acceptance, and the organization knows you're doing it because you're passionate about improving patient care.”

He advises organizations that might be in the earlier phases of digital transformation to “build relationships with people who can help you learn, borrow some

of their successful ideas and push those agendas forward. If your digital ecosystem is not working for you, don't be afraid to change it. Change is hard, but if you're in IT and you're not a change agent, you're in the wrong business.”

We spoke with three providers featured in past IT issues of *Healthcare Executive* to probe how looking back and learning has helped them to move forward.

CentraState Healthcare System and Atlantic Health System: Partnering for Innovation

When *Healthcare Executive* profiled CentraState Healthcare System in a 2015 article on IT innovation, the Freehold, N.J.-based organization had recently been named a “Most Wired” hospital by *Hospitals & Health*

“It's important not to be afraid to try things. There's no harm if you have a culture of acceptance, and the organization knows you're doing it because you're passionate about improving patient care.”

—Jeffrey Sturman
Memorial Healthcare System

Networks. CentraState was considered a trailblazer back then, but a lot more has happened in eight years.

Pivotaly, in 2021, the system entered into a co-ownership agreement with Atlantic Health System, Morristown, N.J. Their combined strength and economies of scale have expanded the scope, reach and efficiency of healthcare services across key regions and synergized digital transformation for both partners, according to Sunil Dadlani, executive vice president and chief information and digital officer for Atlantic Health, and an ACHE Member.

A maelstrom of healthcare disruptors, including consumerization, the pandemic, workforce shortages, changes in reimbursement models and supply chain issues mandated a strategic realignment as CentraState faced the current healthcare environment, he says.

By 2021, Atlantic Health had already made strategic investments in a scalable and agile digital infrastructure. CentraState was able to expand its digital profile exponentially by leveraging this foundation, working as part of a centralized IT organization that caters to the needs of each system while minimizing redundancy. The IT organization has a joint business governance framework that brings clinical and nonclinical leaders and IT team members together to discuss business needs and use cases. Dadlani says this structure helps ensure a standardized-but-flexible systems approach to IT.

A go-live for CentraState on Atlantic Health's system was achieved within a record-setting six months, making it the fastest implementation on this platform worldwide. The IT leadership's guiding principles for both organizations helped expedite the timeline, according to Dadlani. They included an agreement by CentraState to adopt Atlantic Health's IT processes and policies organizationwide.

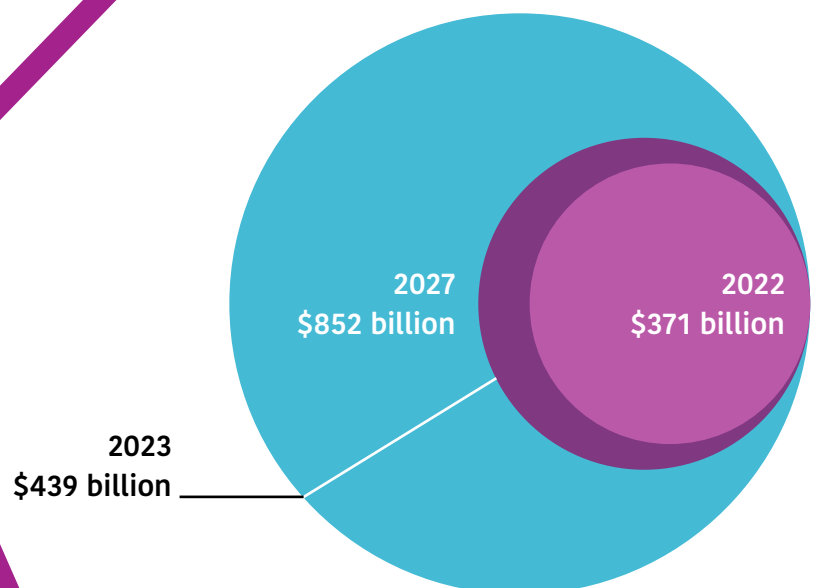
Within four months, quality improvements at CentraState included an increase from 80% to 98% in computerized physician

order entry rates, a significant reduction in hospital-acquired pressure injuries, and revenue cycle performance in the 75th percentile or higher in 10 of 11 core metrics.

Despite this progress, Dadlani believes a lot could go wrong if the organizations did not incorporate healthy doses of honest reflection and evaluation into their IT initiatives. "You can't design your IT road map in isolation. You have to look in the rearview mirror and connect the dots between past, present and future," he says.

Dadlani stresses the importance of having the organization's strategic plan as the digital road map's driver. Initiatives can go awry without clear goals and alignments to business needs and priorities, effective communication around change management, and buy-in from and collaboration with stakeholders. "We've needed to become more prudent and

The global healthcare technology market is expected to grow 18.3% in 2023 and nearly double by 2027.



Source: ResearchAndMarkets.com's Healthcare Technology Global Market Report 2023.

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LOOKING BACK TO MOVE FORWARD

methodical about making sure we've learned these lessons by aligning tightly with the business strategy across both organizations," he says.

Other lessons learned include setting a goal to further develop the strategic value of digital technology. "The key is learning how to invest judiciously and systematically in a way that will help create competitive advantage," Dadlani says.

Experience has also taught the system the need for a scalable and flexible IT infrastructure designed with interoperability in mind. The need for that interoperability became glaringly clear during the pandemic when CentraState ran into problems around data-sharing with patients, providers, and state and federal agencies. "Proof of concepts and proof of value mean little without the ability to scale at the enterprise level and seamlessly share data," Dadlani says.

He also stresses another ingredient to CentraState/Atlantic's success: an emphasis on diversity and gender balance that has brought depth and richness to the IT team and strengthened performance. "We are always experimenting," he notes, "but we learn fast. We pivot, adapt and recalibrate to keep pace with our organizations' business needs and where the industry is heading."

UCLA Health: Seeking Digital Solutions to Issues of Access

Profiled in *Healthcare Executive* in 2019, Ronald Reagan UCLA Medical Center, UCLA Health's flagship hospital, was one of the first institutions in the United States to use telemedicine in the perioperative space. Patients who are triaged by the anesthesiologists to receive a virtual preoperative assessment are able to log in at home from a personal device that is connected to their EHR. These

patients undergo a remote comprehensive evaluation by a member of the anesthesia team. Photos of the airway taken during the exam are embedded in the EHR.

The remote technology's strong convenience factor helps

reduce no-show rates across surgical specialties, demonstrating telemedicine's effectiveness as a tool for improving access in one of the country's most traffic-congested areas. The technology's benefits became evident even before the pandemic jump-started telehealth's large-scale adoption nationwide.

What a difference a crisis makes. In the year before the pandemic, UCLA Health's remote visits

totaled roughly 3,000, and the perioperative telemedicine program saw about 180 patients. Since then, remote services have expanded by several orders of magnitude, states Chidinma Chima-Melton, MD, FCCP, medical director of quality and telehealth at UCLA Health. Telehealth visits for ambulatory care reached their zenith during the height of the crisis, when physicians conducted 500,000 in a single year.

The system's less than 1% telehealth rate before the pandemic soared to 85% after March 2020 and has normalized at 18% of ambulatory visits, she adds, noting that the specialties have settled into their individual comfort zones with the technology.

Because removing barriers to access remains one of the system's key strategic priorities, telehealth continues to figure prominently in the system's digital road map, says Chima-Melton. The cardiac and thoracic surgery program provides an example.

The program sends patients who have undergone coronary artery bypass grafting, lung resections and other

"Proof of concepts and proof of value mean little without the ability to scale at the enterprise level and seamlessly share data."

—Sunil Dadlani
Atlantic Health System

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LOOKING BACK TO MOVE FORWARD

surgeries home early with remote monitoring devices. Two levels of nursing care support patients, including a call center that proactively checks in with patients for signs of potentially concerning symptoms. The program garners high patient and clinician satisfaction ratings while increasing access and revenue by freeing valuable bed space. Notably, the program has led to a 48% reduction in readmissions, Chima-Melton reports.

During the pandemic, the system discovered, not without difficulty, its capacity for being nimble as well as strategic in the face of ferocious change. After a period of merely reacting and adapting to the system's huge influx of patients and increase in telehealth visits, "we started thinking about how to leverage the opportunities for innovation that the rapid shift to telehealth had opened," Chima-Melton says. That led to revisiting the goals for telehealth and developing new use cases.

UCLA Health has since piloted, with a small number of clinicians, asynchronous e-visits for conjunctivitis, gastroesophageal reflux disease and urinary tract infections, and it plans to expand the program to 10 conditions involving more providers. The "store and forward" approach of e-visits enables patients to report symptoms through a portal and for physicians to review and manage these requests later. This allows patients with more straightforward conditions to receive prompt care without an on-site visit, opening appointment spaces for more complex patients.

Chima-Melton says that UCLA Health has learned to prioritize technology initiatives in a way that provides a

built-in buffer against the digital market's frenetic activity. "It's easy to get swept up by the next fad," she says. "We avoid that by making sure our IT goals are aligned with our institutional priorities."

"It's easy to get swept up by the next fad. We avoid that by making sure our IT goals are aligned with our institutional priorities."

**—Chidinma Chima-Melton, MD,
FCCP
UCLA Health**

The institutional priority of population health, for example, translates to an emphasis on projects that are going to affect as many patients as possible. "Does it serve our patients and clinicians well, improve access for vulnerable patients and improve quality? The projects for which we can answer 'yes' to those questions tend to move forward," Chima-Melton says. In keeping with that emphasis, efforts are currently underway to create targeted population health virtual care pathways and implement AI-based "triage" for patient

messages, ensuring that busy clinicians prioritize those with high-risk features.

The blending of telehealth and quality through Chima-Melton's dual roles as medical director for both was fortuitous. "There's so much synergy between them," she says. "We identify care gaps and create programs around them, with telehealth oversight to help make them more efficient. I think it's something more institutions should consider."

Circle Health and Tufts Medicine: A Data Lakehouse in the Cloud

Circle Health, an integrated community healthcare system headquartered in Lowell, Mass., was already immersed in leading-edge work around interoperability when *Healthcare Executive* profiled it in 2018. A part of Tufts Medicine, the principal teaching affiliate for Tufts University Medical School since 2014, the system

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LOOKING BACK TO MOVE FORWARD

has remained something of a pioneer in digital transformation.

In April 2023, all members of Tufts Medicine, including Tufts Medical Center and Lowell General Hospital, Circle Health's flagship institution, went live under one EHR (from a total of 28 different platforms, all of which were working well on their own). In doing so, Tufts became the first health system in the country to move its digital ecosystem completely to the cloud, reports Angel Santana, Tufts Medicine's IT executive director.

The fact that the IT teams across Tufts Medicine's member institutions now operate under a single IT organization parallels the high level of connectedness that characterizes the digital ecosystem itself, Santana says.

As of August 2023, Tufts Medicine's IT function began operating without data centers, thanks to an architecture known as a data "lakehouse" that offers economical storage for all types of data, including clinical data, while supporting machine learning and predictive analytics. "We are a platform company that is totally cloud-first and AI-first," says Shafiq Rab, Tufts Medicine's chief digital officer and system CIO. Rab credits that cloud-first, AI-first philosophy for much of the system's cost savings. The increasing use of application software as well as data in the cloud has reduced not only hardware costs but also the number of applications requiring maintenance from 900 to about 150.

This strong digital foundation frees the IT organization to focus on its mission of serving as "enablers who work to improve efficiency, decrease costs and bring joy through digital innovation to the lives of the caregivers, employees and patients who are our customers," he says.

According to Rab, the ongoing process of cultural transformation required to achieve those connectivity goals has been the most challenging aspect of the IT team's work—proof that a digital transformation is about human factors and change management as much as it is about technology.

"We are a platform company that is totally cloud-first and AI-first."

—Shafiq Rab
Tufts Medicine

A key element of that cultural transformation was creating a sense of urgency around digital technology by involving all stakeholders, including physicians, patients and staff, in the development of the system's digital front door.

The digital front door "is successful because we didn't build it for ourselves, we built it for our caregivers, patients and physicians," Rab says. "That's how we have a clinically integrated network of 2,000 private doctors in our group."

A digital governance committee works to achieve consensus and unite stakeholders around a common mission. "The biggest lesson we've learned is to make sure that all stakeholders have a voice in decision-making," says Santana. "Since they are going to be the people using the system, it's imperative that they feel free to share ideas and be part of the process."

Of course, the risk is having too many voices, but governance helps cut through the cacophony. "It's not that we don't have differences, but we talk them out," says Rab. "And we have a North Star to become the most trusted place for people to come to receive their care. Connectivity across settings is a big part of that. We haven't reached nirvana, but our leaders, staff and physicians are committed to this transformation."

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

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Driving to a Healthier Bottom Line Through UM Optimization

How Adventist Health West centralized and automated utilization management processes.

“From these very deliberate efforts has come a cascading, positive effect that just keeps going.”

— Regina Berman, RN

Value-Based Care Executive
Adventist Health West
Glendale, Calif.

An efficient utilization management program is a vital ally in a health system’s ability to deliver high-quality patient care while managing costs. To become more centralized and efficient, Adventist Health West, a 25-hospital system serving patients in California, Washington, Oregon and Hawaii, overhauled its UM program two years ago and has seen sustainable changes that continue to positively impact key metrics related to patient outcomes, staff satisfaction and healthy financials.

The Challenges

AHW saw the need to increase efficiencies across its disparate organizations through UM centralization, technology enhancements and workflow optimization to improve its bottom line. Prior to the COVID-19 pandemic, UM and inpatient case managers were heavily siloed and saw little success implementing new processes and technologies, even though they were all on the same campus. With the pandemic’s drive to remote work, the siloes became harder to penetrate, and the disconnect among teams, processes and technology was exacerbated, preventing them from addressing their poor financials.

Health system leadership realized what was needed was a more centralized UM model, incorporating standard workflows across all the system’s hospitals, and technology that would increase efficiencies. They also wanted a clinically driven initiative that would have a positive effect on the revenue cycle, resulting in fewer avoidable medical necessity denials, reduced length of stay and healthier financials overall.

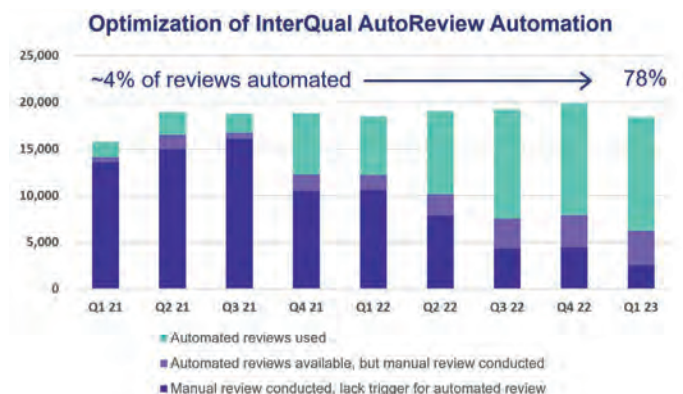
In addition, technology that was implemented prior to COVID-19 was being underused. Staff had access to the InterQual® AutoReview cloud-based solution, which was intended to be used for medical review automation. However, Regina Berman, RN, value-based care executive, Adventist Health West, Glendale, Calif., and colleagues discovered that only 4% of reviews were automated.

“We realized that the way the physician order process was built in our EHR was not ensuring a single order for admissions flowing through, which is what would trigger the technology,” Berman says. “We knew we needed to get together with the medical staff and make a dramatic change in their order-writing process.”

The Solutions

In 2021, leadership decided to implement improvements across all 25 hospitals at once. Some of the most significant moves included:

Clinical workflow changes, including insisting a primary condition-specific admission diagnosis be documented; cross-functional collaboration among the UM, clinical documentation improvement and care management teams; correct use and increased adoption of InterQual criteria (evidence-based criteria used to help ensure clinically appropriate medical-utilization decisions) across teams





and physicians; and a right-sized peer-to-peer review process, with improved completion and overturn rates.

Technological changes, including refinements in the EHR to require the single diagnosis is entered on the admission order, and full use of InterQual AutoReview for automated medical necessity reviews, which reduces the manual burden on staff and increases review accuracy.

Utilization review workflow changes, including a streamlined escalation process that more accurately, and immediately, places patients in the right level of care and enables the UM team to communicate escalations to on-site care teams more quickly.

The Outcomes

In addition to a better care experience overall for patients, who are placed correctly more quickly, staff have experienced greater satisfaction in their work and feel more productive thanks to more sustainable workflows and processes.

“From these very deliberate efforts has come a cascading, positive effect that just keeps going,” Berman says.

Other notable outcomes include:

- Increased generation of automated InterQual reviews via the InterQual AutoReview solution from 4% of reviews automated to 78%.
- Increased productivity, from a goal of reviewing 35 encounters per day (in 2022) to a team average of 40 per day.
- Reduced accounts receivable and medical necessity write-offs, which resulted in:
 - Authorization denials reduced by 70.8%.
 - Inpatient medical necessity/level of care write-offs reduced by 76%.

- Peer-to-peer (concurrent) denial charges overturned (\$78 million total).

Key Lessons

Berman has the following advice for healthcare executives:

Have the right partners at the table. Stakeholders on this initiative included UM leaders, physicians, senior medical officers, revenue cycle and clinical informatics staff, hospitalist groups, and vendors.

Get physicians on board. A cornerstone of the improvements was asking—and then requiring—physicians to enter a primary admitting diagnosis. Because this was a change to their regular clinical workflow, earning physician engagement was critical. Adventist’s physician leader group agreed to educate and get other physicians on board.

Don’t underestimate C-level support. As a member of the C-suite, Berman’s leadership on this initiative sent a strong message that it was a priority. Facing the challenges together as a unified leadership team also was key. “When leaders come together, the teams come together,” Berman says.

Focus on data—and transparency. Data has been essential for AHW’s ability to evaluate progress and refine processes. Case management leaders, medical officers and financial officers receive patient escalation reports for each patient daily, delineated by reason and provider. Staff also receive weekly, monthly and quarterly reports, furthering transparency and staff’s ability to find and correct issues.

“Each leader has what they need to make the next right decision,” Berman says.

For more information, please visit www.InterQualAutoReview.com.



Using Technology to Inspire Patient Engagement

By Ed Finkel

Bolstering meaningful patient engagement is among the top goals and connected uses for technology that health systems are implementing. From a business perspective, they're doing it to ensure continued use of services. But they're also doing it from a medical perspective to ensure continuity of excellent care.



WellSpan Good Samaritan Hospital, Lebanon, Pa., for instance, has engaged with patients through MyWellSpan, a portal that provides them access to their health information and a direct connection to their care team that's linked to WellSpan's EHR system. And it's used frequently: 73% of patients who have had an appointment in the past year have set up an account, and 83% of those with at least three visits have done so, according to Hal Baker, MD, senior vice president, chief digital officer and CIO.

The health system most recently received a 7 on the 0-to-7 EMRAM (Electronic Medical Record Adoption Model) scale, a widely accepted benchmark promulgated by the Healthcare Information and Management Systems Society for how well health systems are engaging their patients. "EMRAM measures specifically what hospitals are doing with EHRs to look at how to achieve best outcomes for patients," says Anne Snowdon, RN, PhD, FAAN, chief scientific research officer at HIMSS.

Among the reasons patients are drawn to MyWellSpan is the

uploading of images ranging from fetal ultrasounds to broken bones, 337,000 of which had been viewed between Jan. 1 and June 23 of this year alone, Baker says. "We actually give you a link to the images," he says. "You can look at a video of your child kicking in the womb and show that to the grandparents. Kids like to have their moms show pictures of their broken bones. ... We always said, 'We want to have the patient portal we want when we're patients or our family needs care.' That's helped us push the limit a little bit."



Using Technology to Inspire Patient Engagement

“If, on a Friday night, somebody cancels an appointment for Monday morning, we don’t have anybody [on the phone] over the weekend to schedule a new appointment. With this system, they can take an appointment at 8 on Monday morning. That allows somebody to be seen. They’re happy.”

—Hal Baker, MD

WellSpan Good Samaritan Hospital

The image links can show a cancer patient visual evidence that their tumor is gone, Baker adds. “Sometimes, emotional healing happens when people can see with their own eyes,” he says. “You can read a report that says your tumor is gone, or you can look at the images and see that it’s gone.”

Another portal feature is online scheduling, along with a “Fastpass” option that automatically sends text messages to those on a waitlist to move up their appointment time. “If, on a Friday night, somebody cancels an appointment for Monday morning, we don’t have anybody [on the phone] over the weekend to schedule a new appointment,” Baker says. With this system, “they can take an appointment at 8 on Monday morning. That allows somebody to be seen. They’re happy.”

And they’re not alone. “It makes the business office happy because nobody has to make a call to reschedule, and it eliminated an unused vacant appointment,” he adds. “We always had online scheduling that people could do themselves—now, the computer is going out and searching for someone to fill that vacancy.”

Tech Adapting to In-Person Needs

Technology also has enabled caregivers to engage patients face-to-face in a way they did before EHRs required so much note-taking. Using an AI-powered product, clinicians can record their conversations, have them automatically transcribed and then converted to a medical note by the AI, have those medical notes

proofread by someone on the vendor’s staff, and drop them into the patient’s chart in less than two hours on average, Baker says.

“A lot of people say that the doctor pays more attention to the computer than to them,” he says. “This allows you to better focus on the patient, rather than type something into the computer.” More than 200 doctors at WellSpan are using the AI-powered, voice-enabled, ambient clinical intelligence solution, and “we’re hearing very, very strong stories about how it lets them do the thing they went to medical school for.”

The product not only transcribes the recording but reorders it so that it’s written as a medical note, Baker says. “If computers can quietly observe and take care of that, we believe our care teams will provide better care and be more empowered and content with their jobs,” he says. “Judges don’t take their own notes. The chairman of the board doesn’t take their own minutes. But we’ve asked doctors to do that.”

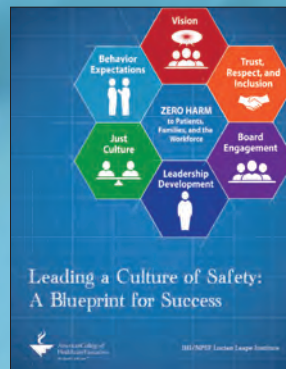
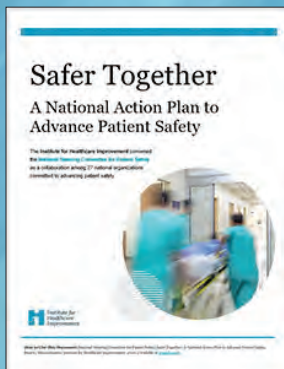
All these innovations are inspired by WellSpan medical staff imagining themselves or their family members as the patient, Baker says. “All of us eventually become patients. Life has a 100% mortality rate,” he says. “We want that caring, compassionate, easy access: care team members that are focused on us and access to our information wherever we are.”

Happy Patients Equals Improved Care

Enabling new and creative uses of its EHR vendor’s patient access

We Lead for Safety

Safer Together: A National Action Plan to Advance Patient Safety and Leading a Culture of Safety: A Blueprint for Success are two notable practitioner-created resources that share a common safety initiative: aiming for zero harm. The National Action Plan focuses on safety from a total system approach, and the blueprint focuses on leaders, equipping them with a guide to oversee care delivery. Both resources complement each other and should be used together in leading the future of zero harm across healthcare organizations.



[ACHE.org/SAFETY](https://www.ache.org/safety)



Using Technology to Inspire Patient Engagement

“There’s a lot of neat ways we’re using technology to keep patients engaged in their healthcare. It’s better for everybody.”

—Robert Molina
Valley Medical Center

portal has been central to patient engagement efforts at Valley Medical Center, Renton, Wash. The organization achieved a 7 on the HIMSS EMRAM scale, improving both outcomes and patient satisfaction, according to Robert Molina, chief digital officer, chief medical information officer and chair of the portal’s committee. “Patient engagement is what it’s all about,” he says. “When patients are more involved, they are happier with their care and their health improves. It’s a win-win.”

The EHR enables care managers to reach out to patients and remind them to schedule a mammogram, for example, or alert them of an abnormal result, Molina says. “Patients with chronic diseases are the ones that really benefit,” he says.

The advantages for patients include easily seeing their lab results and key metrics like blood pressure readings, along with notes from their physician and healthcare team; keeping them informed; and helping with understanding, accountability and worrisome responses or findings.

“This can be very effective in reinforcing lifestyle changes and medication adherence,” says Molina.

Valley Medical Center has added proxy access for families of patients who end up in the hospital, which “is just a game changer,” Molina says. “Families greatly appreciate the insight this provides into the condition of their loved one, particularly those who are out of state.”

Another EHR communication tool that’s proved very popular is automated messages sent as loved ones go through different stages of surgery, which provide designated family members a status update. “There’s a lot of neat ways we’re using technology to keep patients engaged in their healthcare. It’s better for everybody,” Molina says.

For those admitted to the hospital, rooms still have traditional whiteboards with basic information about everything from names of caregivers on shift to what’s available from the cafeteria. But one can also view that information on a smartphone. For those who didn’t bring a phone, the hospital provides an iPad, Molina says. “There’s a lot of patient engagement material on there,” he says, as well as “entertainment options and games. They can see what medications they’re receiving, including links to explain what they’re for, as well as their schedule for the day,” including physical therapy, for example, or imaging tests.

Valley Medical Center also has been making use of the Fastpass, which Molina says with a chuckle makes him think of Disney World’s feature that guests can use to access rides quicker. It fills up empty spaces. “We track how much faster patients get in, and it’s often up to 20 days quicker. Patients love it.”

To encourage even greater use of the system, Valley Medical Center has been delving into the data to determine which kinds of patients use it less frequently, Molina says. “Generally, OB and prenatal patients are very engaged,” he says. “A lot of people thought our seniors would be hard [to attract], but

they're not—they're a lot more tech savvy than we give them credit for. The key there is their grandchildren. They have a great little moment together and get connected."

The hospital's patient and family advisory council, which includes patients from the community, keeps an eye on feedback to ensure they aren't leaving out any groups, Molina adds. "We talk to them, especially, about [the patient portal]," he says. "What are your thoughts? Where are the gaps? They help to steer us and provide guidance on new ideas."

Virtual Registered Nurse

Progress West's use of its patient portal continues to evolve, Molina says.

"Early on, it was used mainly to provide basic information and allow communication," he says. "Over the years it had progressed to something far more sophisticated. It empowers patients to be more involved in their own health and fosters a stronger partnership with their healthcare team."

Virtual nursing has been a positive outcome for everyone at Progress West Hospital in O'Fallon, Mo. The hospital began a pilot project in January for parent company BJC Healthcare (which it hopes to expand systemwide over time), aimed to support nurses at the bedside and hopefully encourage more of them to stay long term while engaging patients earlier and more often. "We looked at the burden of nurses, and even healthcare generally, especially the night-shift staff," says Ekene Ejimofor, DNP, RN, CNO, Progress West, who is also an ACHE Member. "How do we use technology to support the team?"

The program complements front-line nurses in the ED or inpatient units (but not, as of yet, the ICU) who are directly caring for patients with an experienced nurse who appears on screen, via a computer at the bedside, to interact with patients and serve as a mentor for the bedside nurse, Ejimofor says.

The virtual nurse says, "Hello Mr. A, I'm going to be partnering with your nurse at your bedside," he explains. "They go over the admission and ask questions of the patient about what brought them to the hospital. The virtual nurse completes all the initial admission documentation, so the nurse at the bedside doesn't have to spend one or two hours doing the admission."

Progress West has a team of three virtual nurses who log in virtually across different nursing units. "We are hoping that through this initiative, we can retain experienced and highly skilled bedside nurses who may be considering leaving the bedside," Ejimofor says.

"We hear some nurses say, 'I don't want to do bedside anymore. I can't physically lift patients anymore.' We don't want to lose their skills and expertise. And they can support new nurses by mentoring and guiding them while caring for the patient in a different way."

Progress West, which scored a 6 on the HIMSS EMRAM scale, has and will continue to provide specific training to virtual registered nurses in areas where they might not be proficient, Ejimofor says.

"Some of them may not be familiar [enough] with some specific procedure to provide pre- or post-education to

the patient and their families," for example, he says. "A virtual nurse will remote into your room [and say], 'Mr. A, I'm going to provide education on the procedure you're about to have.' If you're not proficient in surgical [previously], we've trained them in some of the basic procedures to provide education and support to the patient."

When the ED overflows and patients are waiting for an inpatient bed, the virtual nurses can start the intake process while the patient is still in the ED, which is a patient satisfier, Ejimofor says.

"Patients no longer feel like their care is not progressing," he says. "When they get moved to the unit, instead of waiting for the physical nurse to provide education, the virtual nurses are able to remote in when the patient doesn't have any care going on [and say], 'Mr. A, let's talk about your medications' or anything that the nurse decides is vital for the patient to be educated on. The virtual nurses are filling those gaps."

Feedback from patients and their families has shown they believe virtual nurses are both more thorough in admission assessment and patient education and appear less rushed than those at the bedside, Ejimofor says.

"They are there for you and you alone at that time," he says. "Allowing the virtual nurse to remote in and complete the admission process gives the bedside nurse time back to deliver other necessary care to their patients."

To date, Progress West has found that virtual nurses have saved bedside nurses about 20 hours per month, Ejimofor says, while the rate of



Using Technology to Inspire Patient Engagement

“The future state will be that when a provider is rounding on a patient, they can activate the virtual registered nurse for collaborative rounding if the primary nurse is engaged with another patient. The physician doesn’t have to wait for the bedside nurse to return.”

—Ekene Ejimofor, DNP, RN
Progress West Hospital

patients whose initial admission documentation has been completed by the end of a nursing shift has spiked from 50% to a high of 90% overall, and 100% in some units. “That means that I, as a nurse, coming on to a new shift, I’m not trying to complete an admission at the start of my shift,” he says. “All the information I need has been documented.”

Progress West will be tracking its progress in retaining nurses, particularly those with less than one year of experience at the hospital, as they gain the support and mentorship, Ejimofor says. They also will be measuring the rate of incidents like patient falls and pressure ulcers as bedside nurses are able to more thoroughly concentrate on the patient rather than paperwork, he says.

“We also have seen a lot of support from our physicians,” Ejimofor says. “The future state will be that when a provider is rounding on a patient, they can activate the virtual registered nurse for collaborative rounding if the primary nurse is engaged with another patient,” he says. “The physician doesn’t have to wait for the bedside nurse to return.”

The cost of the virtual nursing programs consists of the laptop wheeled into a patient’s room—Progress West is also looking into connecting through the televisions in each room—as well as the virtual nurses themselves. But Ejimofor notes that it’s hard to quantify the cost of replacing nurses who otherwise might have left the organization due to lack of support or inability to continue as a bedside nurse. “When you have the support for

new nurses, and even for seasoned nurses, there’s the retention piece, versus the cost of having that nurse leave because they didn’t feel like they had support,” he says.

In what seems like something a “Mission: Impossible” character would use, Progress West will soon begin implementing special internet-connected smart glasses that the nurse at the bedside would wear. The virtual nurse would be able to see exactly what’s in the bedside nurse’s field of vision. These smart glasses will hopefully solve for various use cases in units limited in data drops and space, including skin assessments; high-risk medication signoffs; and admissions, transfers and discharge workflows that require patient visibility to complete the assessment.

“If a nurse is performing wound care and needs expert support, all he or she has to do is to activate a virtual nurse, put on the glasses, and the virtual nurse can see exactly what that wound looks like, and guide the nurse at the bedside and provide recommendations on how to treat that wound,” Ejimofor says.

Whether used for sharing imagery, scheduling appointments, transcribing patient encounters or providing remote care, these technological innovations all in some way provide better focus on and vision into new and improved ways to engage patients, to the benefit of health organizations’ bottom lines—in all senses of that term.

Ed Finkel is a freelance writer based in the Chicago area.

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Expanding Capacity Through Efficiencies

Innovative processes, teamwork and technology help one hospital streamline discharges and improve patient flow.

“It’s a proactive approach, but we know in real time what is happening. We don’t have to be glued to a dashboard or census report to get the pulse of the hospital.”

—Kathy LeFrancois, RN

Director, Patient Flow and Nursing Resources
Sarasota Memorial Hospital–Venice
North Venice, Fla.

Nov. 11, 2021, was a joyous day for Kathy LeFrancois, RN, and her colleagues as they gathered for the grand opening ceremony of Sarasota Memorial Hospital–Venice in North Venice, Fla. Anticipating 75% capacity, staff for the new 110-bed, full-service, acute-care facility was prepared for the opening. Almost immediately, however, the hospital would be over capacity.

“We saw firetrucks and ambulances coming through the parking lot, and we thought at first it was the county celebrating our opening,” says LeFrancois, director, patient flow and nursing resources. “But it was patients in need of care at the ER doors.”

Creative Solutions

Even though relief was on the distant horizon—a new five-story patient tower is set to open on the hospital’s campus in 2024, increasing capacity by 102 beds—the team needed to work within its existing reality.

“We had to create capacity through efficiencies,” LeFrancois says. “At the same time, we wanted to instill among our staff the importance of establishing a high level of care and making patients feel like they are important and not just being rushed in and rushed out.”

LeFrancois and the team were using many of the established processes in place at the 832-bed Sarasota Hospital 20 miles away and also part of the Sarasota Memorial Health Care

System. But they needed to get even more creative to handle the volume at Venice, which was built to serve the growing south Sarasota County area. Some of the additional innovations Sarasota Memorial Hospital–Venice implemented include:

Strategic use of licensed practical nurses. One of the first decisions the team made was to place an LPN on the inpatient floors to focus solely on patients who were ready to be discharged. The LPN meets one-on-one with these patients to go over discharge instructions and provide education on their health conditions, allowing floor nurses to spend time on other patients.

The hospital now has three LPNs on the day shift working solely on discharges, a mid-shift LPN focusing on patient flow from the ER, and a night shift LPN who focuses on admissions and other patient flow needs.

Lightning rounds. Three months after opening, the Sarasota Memorial Hospital–Venice team established rounds in which the hospital’s LPNs go to the units first thing in the morning with the charge nurses and case manager. They flag any patients who are medically cleared and could go home before 1 p.m. The team also flags patients who potentially could be discharged but are being prevented from doing so because of the need for an MRI or other test.

Centralized discharge expediting. A dedicated discharge expeditor, who works from a central logistics center at the Sarasota Hospital campus, receives notifications of these discharge barriers at both hospitals and the system’s freestanding ED in North Port and contacts the units at these facilities to ensure confirmed or potential discharge patients are priorities. Nurses on the lightning rounds also receive the notifications on their mobile devices and work



to expedite the final care steps these patients might require prior to discharge.

Dedicated patient flow oversight. A patient flow coordinator was added to the Sarasota Memorial Hospital–Venice ED to review every admission and make sure clinicians are completing admission orders and recording required patient vitals. LeFrancois says establishing this role has been essential for streamlining patient flow.

“These coordinators have established relationships with both our hospitals’ teams, and they’re the first point of contact when a physician has a concern or a question about placement or when we’re looking at capacity transfers,” she says.

Door-to-car program. The hospital’s orthopedics program features valet appointments for patients with their physical or occupational therapists. On a patient’s discharge day, their final therapy appointment is the therapist helping the patient get into their family member’s or friend’s car to go home. This helps educate patients about how to safely move their healing bodies. These valet appointments have resulted in planned discharge times for some orthopedic patients.

“We have been able to plan that at least 50% of our orthopedic surgeries will leave the next day, so we can prep for either planned incoming surgeries or holds from the ER,” LeFrancois says.

Tech Ties It All Together

Supporting these innovative processes and teamwork is advanced technology that helps staff proactively manage discharge barriers and predict patient surges. LeanTaaS’ iQueue for Inpatient Flow allows the team at Sarasota Memorial Hospital–Venice to access the same information

at the same time so they can effectively communicate discharge readiness and align on discharge priorities.

The hospital has set up notifications within the software about patient capacity, and when specific thresholds are met, automated alerts are sent via text and email to the appropriate staff.

“The software takes into consideration who is coming into the hospital and who is going out,” LeFrancois says. “It’s a proactive approach, but we know in real time what is happening. We don’t have to be glued to a dashboard or census report to get the pulse of the hospital.”

For at least the past six months, Sarasota Memorial Hospital–Venice has discharged 30% to 50% of its census each day before 6 p.m. This has created room for new patients earlier in the day, resulting in decreased ED boarding, fewer patients leaving without being seen, and a reduction in avoidable days and length of stay.

A goal initiated by the hospital’s capacity steering committee—to discharge patients within 403 minutes after they’ve been identified as needing no further care—has been far surpassed; the hospital’s current average is 327 minutes. Nearly 33% of patients are being discharged prior to 1 p.m.

When the new patient tower opens, LeFrancois and her team plan to operate with the same sense of urgency to discharge patients as efficiently as possible.

“That’s the culture we’re creating, and we’re going to stick with it,” she says. “We’ve proven it’s how we can be the most efficient.”

For more information, please contact Kayla Vasey, LeanTaaS, at kayla.v@leantaas.com.



William A. Nelson, PhD,
HFACHE



Susan A. Reeves, EdD,
RN

A Learning Healthcare Systems Approach

Address recurring ethical issues to decrease them.

Several highly recognized thought leaders in healthcare are encouraging organizations to become “learning healthcare systems,” which the Agency for Healthcare Research and Quality describes as a “health system in which internal data and experience are systematically integrated with external evidence, and that knowledge is put into practice. As a result, patients get higher quality, safer, more efficient care, and healthcare delivery organizations are better places to work.”

The National Academy of Medicine and the National Institutes of Health also are proponents of the learning healthcare systems model.

Healthcare organizations across the country have implemented this approach by being more systematic and data driven in gathering and applying both internal and external knowledge to improve the efficiency and quality of patient care they deliver. The domain of patient care has tended to be the focus of this strategy. For example, the learning healthcare systems approach uses data and evidence to improve stroke care and patient outcomes, decrease outpatient wait times, or help to prevent medical mistakes.

An area of focus that has received little attention in the development and implementation of learning

healthcare systems activities is how to gather data and learn from ethical conflicts. This is an area ripe for intervention.

The concept of seeking approaches to decrease the number of ethical challenges and their inherent organizational impact on the staff, patients and the organization is not new. In 1990, Robert Arnold and colleagues published the article, “Preventive ethics and the promotion of ethical decision-making” in *Clinical Respiratory*. Additional articles have also been published that affirm the importance and the value of the concept of “moving ethical conflicts upstream.” A few published models for performing an ethical decision-making process have included a final step focusing on what can be done in the future to prevent the same type of conflict. Despite this important approach to ethics conflicts, few ethics programs or committees have systematically implemented this preventive approach (the exception being Veterans Health Affairs facilities).

Examples of frequently experienced ethical conflicts include:

- Patient or families demanding an intervention that physicians do not want to perform because it is outside the standard of care.

- Decision-making for minors.
- Racist patients.
- Surrogates not making decisions based on a patient’s desires.
- Administrator and clinician engagement in conflicts of interests.

In addition to being frequent, many of these kinds of ethical conflicts are recurring, impacting quality, value of care and professional standards. The presence of these repeat ethical conflicts often fosters staff moral distress that can lead to burnout, dissatisfaction and job turnover. Furthermore, repetitive ethical conflicts can negatively affect an organization’s margin. When an ethical conflict occurs, the organization incurs immediate direct costs associated with the time that the involved staff and ethics consultants spend on addressing the situation, thus decreasing staff efficiency in fulfilling other duties. Some ethical conflicts also bring about legal and risk management costs. A learning healthcare systems approach can help ethics committees and organizations address recurring ethical conflicts and their implications.

Many ethical conflicts are addressed and resolved through the development of clinical and organizational ethics committees, and using consultation services; however, the resolution of the specific conflict is only

one important step. Rather than only responding to ethical conflicts through in-the-moment provision of ethics consultation services, the learning healthcare systems organization approach should be applied to the work of ethics committees by regularly using improvement methodologies to decrease the presence of ethical conflicts.

Implementing a learning healthcare systems approach means that data related to ethical conflicts is routinely collected, categorized and analyzed. The data would include the kind and location of the conflict, as well as the contextual elements contributing to the conflict. The data is continuously aggregated and analyzed. The collection of such information related to ethical conflicts can be incorporated into an improvement process to anticipate or potentially prevent the issue from actually becoming a conflict requiring an intervention.

To illustrate, ethical conflicts surrounding the issue of medical futility occur regularly in the inpatient setting. The situation transpires when a patient or family member demands a level of care or intervention that the healthcare team knows will be nonbeneficial in achieving the care management goals. The healthcare team experiences intense moral distress from the situation and seeks insight from the ethics consultation service. As a result of multiple conversations, the healthcare team, ethics consultants and the patient reach an agreed-upon sound care management approach.

Rather than the situation ending with the patient and healthcare team reaching an agreement regarding the appropriate management approach,

the ethics consultants seek a meeting with the involved staff. This step is a recognition that the basic ethical conflict regarding patient demands for nonbeneficial interventions has occurred frequently in the particular clinical setting. The ethics consultants and others meet to discuss potential improvement approaches with the various involved stakeholders to explore two fundamental questions. The first question, without casting blame on anyone, is why did the ethical conflict happen? The second question is, as a healthcare delivery system, what could be done differently to diminish similar future situations from becoming an ethical conflict?

.....
The learning healthcare systems approach uses data and evidence to improve stroke care and patient outcomes, decrease outpatient wait times, or help to prevent medical mistakes.
.....

Such thoughtful reflections could lead to the creation of ethics practice guidelines and staff education regarding an ethically justified approach to such situations. The development, implementation and assessment of the prevention strategy could lead to a consistent ethically grounded approach in the area where the conflict occurred. The strategy could also be shared with other areas in the organization to cultivate a consistent approach to such recurring situations. There are several steps that can be

implemented by organizations and their leaders to ensure that ethics committees are applying the learning healthcare systems approach.

- Cultivate the collaboration among clinicians and administrators, quality improvement professionals and ethics committee members to capitalize on the synergy of organization and ethics committee aims.
- Review and expand the functions of ethics committees in light of the preventive ethics literature.
- Expand the knowledge and skills of ethics committee members to include competency in learning healthcare systems thinking and methods.
- Consider the inclusion of recurrent ethical conflicts in the organization's learning healthcare systems priorities.

Learning healthcare systems have emerged in organizations throughout the country to enhance the quality and value of healthcare. The work of ethics committees can be used within the concept of learning healthcare systems, and it can be applied to address recurring ethical issues to decrease them, including their inherent organizational impact, and foster an ethical, aligned healthcare culture and organization. ▲

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



Sree Duggineni



Richard Flask

Streamlining the Supply Chain

City of Hope National Medical Center initiative reduced delays to patient care.

Since 2019, and each year following at City of Hope National Medical Center, Duarte, Calif., patient volumes have increased by more than 20% due in large part to the number of expansions to the organization's service lines, the opening of new clinics and an increase of inpatient services. As a result, medical and surgical supplies stocked in clinical periodic auto replenishment, or PAR, systems have struggled to keep pace with both volume and the diversity of care needs.

City of Hope's supply chain challenges have affected the availability of primary items configured on PAR systems. To meet the growing demand, it has been necessary to replenish inventory with nonstock substitute items and expand the breadth of substitute items available. The stocking quantities of most supplies, however, has been too low to adequately meet patient care needs.

This led to an increase in the time the clinical staff spent on tasks peripheral to their core responsibilities. Those responsibilities include requesting, waiting for, and locating medical and surgical supplies that were unavailable or not found within their respective department's PAR systems.

Overall Program Objective

To address the supply chain management issues within the PAR

environment, City of Hope had a two-fold objective. The first was to enable clinicians, especially those within the nursing department, to perform at the top of their license to provide the best patient care experience and achieve professional fulfillment in the process. The second part of the overall program objective was to foster an environment that is operationally efficient and excellent in its practice. This would be achieved by reducing the supply chain resource time on ad hoc and unplanned activities by having the correct items stocked at the correct levels on each PAR. Furthermore, to sustain this efficiency and time management, the organization established standard operating procedures.

The goal established was to reduce the time clinical personnel spent on requesting, waiting for and locating supplies to fulfill their duties. This, in turn, would yield a reduction in delay of care provided to patients, minimal clinician time away from the patients in their care and optimized use of supply chain resources, which would drive improved supply availability and stabilize the timely delivery of that inventory from central supply.

Issue and Root Cause Identification

The impetus for the supply chain initiative initially surfaced during an

interdisciplinary rounding exercise, when the clinical staff identified the availability of the right supplies at PAR locations as a challenge. Subsequently, members from the supply chain team performed an in-depth root cause analysis to quantify the identified challenge and determine the key factors contributing to the ongoing issue.

A 12-month baseline of data was used to establish an average number of daily ad hoc supply requests, as well as the impact on resource utilization, clinician satisfaction and patient experience. From there, the root causes for the significant number of supply walk-up calls were determined using a series of activities such as supply chain rounding of the clinical areas, daily huddles, bed meetings and one-on-one engagement with select front-line clinical staff.

A Pareto analysis, based on the idea that 80% of a project's benefit can be achieved by doing 20% of the work, was then developed based on the clinical feedback and documented

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observations. The program scope and implementation plans were built with the focus on addressing the root causes identified in the analysis from the proposed parameters by applying the 80-20 rule to prioritize efforts on those root causes driving 80% of supply walk-up events.

Implementation

Working collaboratively, supply chain and clinical leaders developed the program plan and implementation methodology. The following activities were included in the initial implementation:

- Determined preliminary stocking levels at each PAR location for supplies recommended to be maintained in stock inventory, based on historical usage and patient volume projections.
- Engaged with front-line clinical staff to understand operational workflows that would need to be factored into stocking level

calculations. For example, supplies that are being pulled from PARs to stock carts inside clinic exam rooms.

- Reviewed data-based recommendations for supply quantities with clinical staff, incorporated their input and obtained their sign-off.
- Developed consistent space design to better organize supplies across all PARs, in collaboration with staff nurses and their managers. Doing so enabled easier location of supplies for clinicians who are moving across different patient care areas.
- Updated the enterprise resource planning system with revised PAR quantities by location so that replenishing supply quantities was more closely aligned and managed with user demand by location.
- Implemented agreed-upon changes to the supply PARs, as per the project plan timelines.

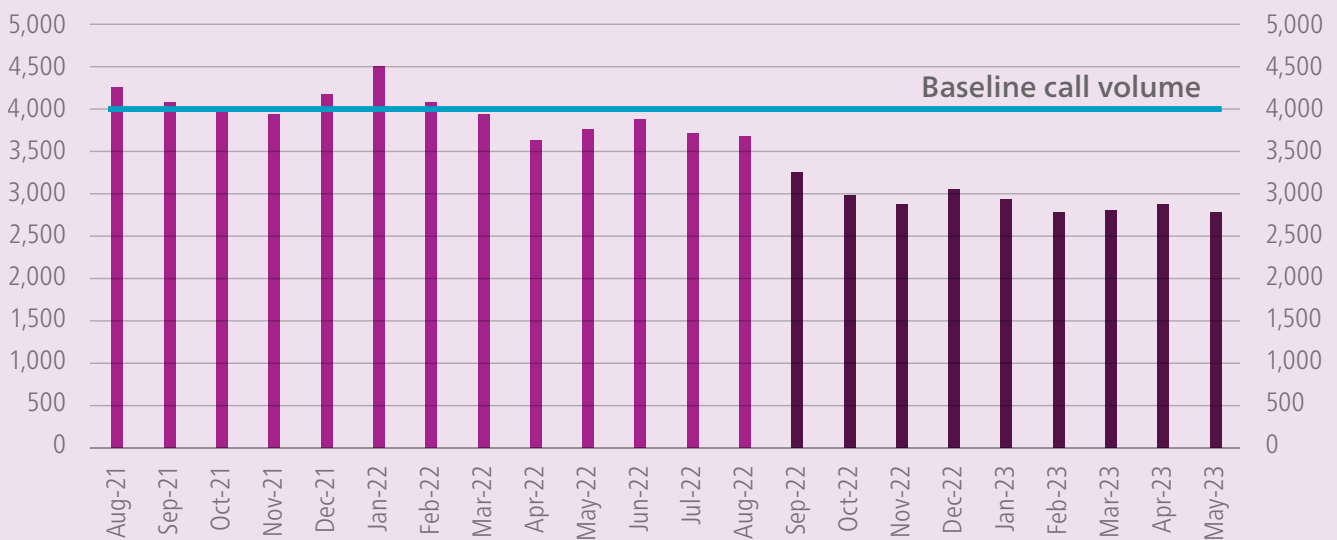
- Initiated and sustained change management efforts, including clinical staff communication, clinical and supply chain staff training, and tracking of key performance indicators.

Robust change communication and training efforts were activated to drive successful adoption of the program with over 1,500 members of clinical and supply chain staff across three shifts. Key elements of the change management efforts included public sponsorship and endorsement of the program by nursing executive leadership.

The program became a standing topic for updates and discussion at various clinical forums such as inpatient and outpatient nurse manager meetings.

Several metrics and KPIs, including daily ad hoc supply request volume by service line and clinical staff member and nightly supply fill rates, among others, were activated to

Ad Hoc Supply Request Call Volume



monitor the adoption and success of the program and gather data to inform and provide insights for continuous improvement efforts as the program becomes more ubiquitous.

Outcomes

The qualitative benefits from this program included improved quality of communication and strengthened collaboration as well as partnership between nursing and supply chain departments. Also, nursing leaders adopted shared goals with supply chain leadership that are focused on ad hoc supply call volume reduction to demonstrate the strategic and collaborative nature of the partnership.

These collective efforts helped reduce delays to patient care, especially at

the clinical lab and outpatient clinic service line locations. In addition, the supply chain department became a strategic partner to clinicians and clinical leadership in their efforts to create a top-of-license environment.

Quantitative benefits included a 25% reduction in ad hoc supply requests during the first three-month period post-implementation. Ongoing continuous improvement efforts have led to further supply call volume reduction, which now stands at 30% below the 12-month program baseline. This reduction has helped free up the equivalent of one full-time supply chain resource, which has been repurposed to support regular and proactive assessment of PAR demand. The call volume reduction

has translated to a 30–45 minute-per-day reduction in nursing time spent on peripheral tasks.

Supply chain teams in healthcare systems can play a critical role in supporting the creation of a top-of-license environment as the systems continue to navigate the challenges with labor shortages and increasing cost of care. ▲

Sree Duggineni is executive director, supply chain operations, Supply Chain, City of Hope National Medical Center, Duarte, Calif. (sduggineni@coh.org), and an ACHE Member. Richard Flask is director, supply chain operations, Supply Chain, City of Hope National Medical Center, Duarte, Calif. (rflask@coh.org), and an ACHE Member.

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Diane L. Dixon, EdD

Leadership Is Essential for Strategic Change

It ensures every team member plays a role in contributing to the work.

Diversity, equity and inclusion are at the heart of the healthcare mission. Some leaders say DEI is the DNA of their health system. The core purpose of health systems is to provide quality healthcare to diverse populations and to play a key role in developing healthy communities.

The diverse workforce and health equity initiatives to serve diverse patients and communities are interconnected and interdependent.

A commitment to equity and mitigating healthcare disparities is inextricably linked to mission-critical continuous quality improvement and patient safety. Achieving the healthcare mission depends on diverse people working in an inclusive workplace, where they feel a sense of belonging and their well-being is seen as central to attaining the mission. All of this requires inclusive leaders who believe DEI is a strategic priority that involves strategic change to be successful.

What Is Strategic Change?

Strategic change is organizational change that is aligned with the

strategy and addresses the cultural adaptation required to achieve it. DEI is more than a series of programs and initiatives. Programmatic change often does not lead to sustainable results. A seminal article “Why Change Programs Don’t Produce Change” by Michael Beer, Russell A. Eisenstat and Bert Spector, which appeared in the November/December 1990 issue of *Harvard Business Review*, makes this point. Diversity, equity and inclusion is a strategy that needs to be embedded in the mission, core values, vision and goals. Change leadership efforts focus on creating a diverse, equitable and inclusive organizational culture. There needs to be coherence and alignment of DEI goals, key performance indicators, priorities, decisions, and actions with the strategy and culture to attain sustainable results.

Leadership Practices for Sustainable Results

Leadership practices needed for sustainable DEI results has been the subject of research studies and articles. One example is the May 2021 *Harvard Business Review* Analytic Services and Society of Human Resource Management research report, *Creating a Culture of Diversity, Equity, and Inclusion: Real Progress Requires Sustained*

Commitment, describing the survey outcomes from 1,115 organizational leaders. The study explored the extent to which DEI is a strategic priority, methods for implementing DEI initiatives and the level of success with developing a DEI culture.

Another example is the article “Diversity, Equity and Inclusion Lighthouses 2023” by McKinsey & Company in partnership with the World Economic Forum, which described the work of the Global Parity Alliance, a multi-industry group committed to advancing DEI worldwide. The alliance studies successful DEI initiatives (“lighthouses”) to determine common factors that yield scalable, quantifiable and sustained impact. In addition, my interviews with senior leaders at organizations such as Luminis Health and CHRISTUS Health about DEI leadership suggest effective leadership practices for DEI strategic change. The leadership practices and actions described here draw from these studies and interviews.

Top executive commitment to DEI as a strategic priority.

Top leadership commitment includes the CEO, the executive leadership team and the board. Commitment goes beyond statements and is demonstrated by actions that model dedication to an inclusive and equitable organizational culture. Strategic change in DEI requires a long-term investment. For example, at Luminis Health and CHRISTUS Health, the DEI work officially began with signing the American Hospital Association’s #123 for Equity Pledge in 2015, and their leadership commitment continues.

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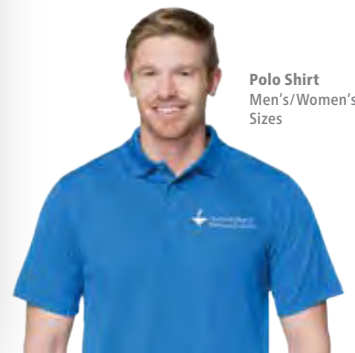
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DEI embedded in the organizational strategy and culture.

Diversity, equity and inclusion are at the heart of the mission and core values. Strategic DEI initiatives are aligned with the organizational strategy and vision. This is the way the organizations that make sustainable progress do business; DEI is the culture—beliefs, values, behavioral norms and underlying assumptions—focused on being inclusive and equitable. Systems, policies, procedures, power structures, rituals and routines are aligned with DEI principles. The diverse workforce and health equity initiatives to serve diverse patients and communities are interconnected and interdependent. For example, CHRISTUS Health developed a *DEI Strategic Multilevel Framework for Sustainable Solutions* that embodies internal, interpersonal, institutional and systemic pillars showing the interrelationships to help leaders navigate complex strategic change.

Quantitative and qualitative measures of success.

Clear definitions and measures of success are important. These measures are typically quantitative and qualitative. Quantitative measures may include employee engagement surveys and recruitment targets to increase senior executive diversity. Qualitative measures might include employee listening sessions to learn about lived experiences with DEI in the organization. Metrics and benchmarks for DEI establish performance expectations, evaluate progress and guide decision-making. Rigorous tracking of goals and performance scorecards help to identify change interventions and course corrections. The data

informs learning needed to facilitate progress toward goal attainment.

Accountability and learning environment.

Accountability for achieving DEI goals begins at the top. Some health systems have DEI accountability metrics linked to executive pay-at-risk or performance bonus programs. Clearly defined expectations are integrated into the performance management system. Rigorous tracking of key performance indicators enhances accountability and learning for continuous improvement. Accountability for achieving results works best in a learning environment in which mistakes and performance gaps are viewed as learning opportunities that help identify interventions for change.

Communication, transparency and engagement.

When DEI is a core business priority, it is visible and integrated into the day-to-day operations of the organization. Engagement and inclusion of all stakeholders are critical for success. There is routine communication about DEI goals, achievements and opportunities to improve performance. These goals are frequent topics on executive and leadership team meeting agendas. Communication and dialogue about goal progress and improvement are the norm systemwide. People see DEI as an important part of their jobs to serve patients and communities. This inclusive and interactive communication boosts engagement on all levels of the system.

Resistance to change managed constructively.

Resistance to DEI strategic change is expected. Successful organizations manage resistance to

change constructively in a manner that maintains positive relationships rather than shutting them down. Leaders listen with empathy to understand negative reactions and use them as sources of learning that can inform the change strategy. Data and stories about disparities between goals and actual results are tools that facilitate learning and performance improvement. Everyone in the organization may not agree with DEI goals, but in an inclusive environment where diverse thinking is valued, people are more likely to participate in a constructive manner.

These practices work together in an inclusive transformational leadership approach to leading strategic DEI change. Inclusion means all people in the health system are treated with respect and are accepted and valued. People feel a sense of belonging. Transformational leaders inspire and develop leadership on all levels, stimulate innovation and encourage participation in achieving a mission that embodies DEI principles.

Inclusive transformational leadership removes barriers to DEI strategic change, such as tight hierarchy and siloes, to facilitate teamwork across boundaries and make the difference required for achieving sustainable results. This leadership approach increases knowledge and awareness and works toward an organizational alignment that ensures every team member plays a role in contributing to the work. ▲

Diane L. Dixon, EdD, is a leadership and organization development consultant/adviser, educator and author (diane@ddixon.org), Columbia, Md., and an ACHE Member.



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Paul H. Keckley, PhD

Analysis of Healthcare Spending Since 2000

A 21-year retrospective provides insights on the health economy.

Year-over-year changes in U.S. healthcare spending reflect shifting demand for services and their underlying costs, changes in the healthiness of the population and the regulatory framework in which the U.S. health system operates to receive payments. Fluctuations are apparent year-to-year, but a multiyear retrospective on health spending is insightful in understanding the big picture.

An Eventful 21 Years for U.S. Healthcare

The period from 2000 to 2021 (the last year for which U.S. spending data is available) spans two economic downturns (2008–2010 and 2020–2021); four presidencies; shifts in the composition of Congress, the Supreme Court, state legislatures and governors' offices; and the passage of two major healthcare laws (the Medicare Modernization Act of 2003 and the Affordable Care Act of 2010). During this time span, there were notable changes in healthcare spending, according to the Centers for Medicare & Medicaid Services' National Healthcare Expenditure data:

- National health expenditures were \$1.366 trillion (13.3% of gross domestic product) in 2000 and \$4.255 trillion in 2021 (18.3% of the GDP). This

represents a 210% increase in nominal spending and a 37.5% increase in the relative percentage of the nation's GDP devoted to healthcare. No other sector in the economy has increased as much.

- In the same period, the population increased 17% from 282 million to 334 million, as per capita healthcare spending increased 166% from \$4,845 to \$12,914. This disproportionate disconnect between population and health spending growth is attributable primarily to unit costs in healthcare—the prescription drugs, facilities, technologies and specialty provider costs that escalate faster and higher than costs in other industries. Economists have observed that supply-induced demand and lack of competition are major contributors to the health-cost spiral.
- There were notable changes where dollars were spent: Hospitals remained relatively unchanged (from \$415 billion/30.4% of total spending to \$1.323 trillion/31.4%), while physician services shrank (from \$288.2 billion/21.1% to \$664.6 billion/15.6%). Prescription drugs also remained unchanged (from \$122.3 billion/8.95% to

\$378 billion/8.88%), whereas public health spending increased slightly (from \$43 billion/3.2% to \$187.6 billion/4.4%).

- There were also striking differences in sources of funding: Out-of-pocket spending shrank from \$193.6/14.2% of payments to \$433 billion/10.2%, and private insurance shrank from \$441 billion/32.3% to \$1.21 trillion/28.4%. Conversely, Medicare spending grew from \$224.8 billion/16.5% to \$900.8 billion/21.2%; Medicaid and the Children's Health Insurance Program spending grew from \$203.4 billion/14.9% to \$756.2 billion/17.8%; and Department of Veterans Affairs healthcare spending grew from \$19.1 billion/1.4% to \$106 billion/2.5%.

These data point to a problematic trend: The healthcare economy is increasingly dependent on indirect funding by taxpayers and less dependent on direct payments by users. During the last 20 years, local, state and federal government programs like Medicare and Medicaid have become the major sources of healthcare funding. Direct payments by consumers, vis-à-vis premium and out-of-pocket costs, have not kept up with medical inflation and utilization and contribute less in the aggregate. As the population ages (people who are 65 and older increased 29% from 44 million/12.4% of the population in 2000 to 57 million/17.1% of the population in 2021), the burden for funding healthcare will increasingly shift to the working-age population and their employers, who pay the bulk of taxes.

The Big Picture

These data present a perplexing and immediate challenge for healthcare policymakers and government officials for the following two reasons:

- **Allocation.** How should funds be spent to achieve optimal value in the health economy? Public health programs that address social determinants of health (food insecurity, loneliness, unsafe housing, etc.) for underserved populations receive less than 5% of U.S. health economy spending but account for up to 70% of its costs. Investments in primary and preventive health reduce demand and mitigate

more expensive specialty care, but the majority of the health economy's funds go elsewhere.

- **Sourcing.** Where should health economy funding come from? The National Healthcare Expenditure data show the health economy is increasingly dependent on government sources for its funding as out-of-pocket and private insurance payments shrink. As the health economy competes for public funds against education, transportation and environmental safety, will it merit taxpayer confidence in its stewardship? Or will those with connections to financial sources, such as private equity, drive innovations accessible only to those to

whom a shareholder return is expected?

Healthcare is expected to consume 20% of the nation's GDP by 2030, owing to high unit costs, medical inflation and increased utilization. Affordability, price transparency and equitable access to care will be prominent issues in the 2024 election cycle as criticism mounts regarding hospital consolidation and business practices in not-for-profit settings. This means the healthcare economy will face intense scrutiny to justify the oversized role it plays. ▲

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



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Tracy L. Duberman, PhD, FACHE

The Healthcare Leadership Pipeline

Strategic succession management helps organizations innovate.

Healthcare executives and their teams are no strangers to change, and part of that change is the result of turnover from executive leaders retiring or leaving for new roles. Hospital CEO positions turned over at a rate of 16% for the third consecutive year in 2022, according to a recent report by the American College of Healthcare Executives. This turnover forces board members, the remaining executives and human resources leaders to address gaps in talent that they may or may not be ready to fill.

Many healthcare organizations create and implement succession plans that identify individuals who are capable of filling critical leadership positions. Strategic succession management is ongoing, starting even before an incumbent leader begins to consider their departure. This process identifies the critical skills, experiences and competencies required for an organization’s future success and, therefore, a pathway to assess and develop select leaders for future roles, ensuring business continuity and future growth.

Why Succession Management Is Important

In today’s rapidly changing landscape, numerous factors make strategic succession management even more critical, which can include:

Rising competition for market share.

Mergers and acquisitions among technology, retail and other nontraditional healthcare players are causing a critical mass of patients to receive primary and urgent care outside of health systems. Successful succession management in traditional health systems ensures continuity of vision and stakeholder relationships so that the health system’s unique perspective remains at the forefront as new partnerships are forged with other sectors to maintain critical market share.

Recruiting and retaining top talent.

Among strategic initiatives that human resources leaders are prioritizing for 2023, more than 50% of organizations expect competition for talent to increase this year, according to a recent Gartner survey. In addition, 36% said their sourcing strategies were insufficient for finding the skills they need. To recruit new talent and keep top employees in-house, organizations must have a plan to meaningfully invest in, develop and promote leaders.

Managing rising costs. Hospitals’ total expenses, including labor, drug and supply expenses, rose 21% between 2022 and 2023, according to a May 2023 report from Kaufman Hall. Leaders will need financial savvy and institutional knowledge to decide which investments are

essential and timely. Developing internal candidates for senior roles as part of a succession plan ensures a seamless transition of leadership, fostering stability and continuity in organizational operations, decision-making and strategic planning, ultimately contributing to financial stability in the future.

Adapting to new technologies.

Forbes contributor Robert Pearl, MD, noted in his article “5 Ways ChatGPT Will Change Healthcare Forever, For Better” that more tasks in healthcare are beginning to lend themselves to automation and support from artificial intelligence. Succession management can play a pivotal role in identifying and cultivating leaders who are capable of harnessing new technologies required for future growth.

Well-developed succession management ensures that organizations have the right people in key leadership positions today and that qualified leaders can fill these positions in the future. Strategic succession management also ensures that healthcare organizations remain competitive, even as the landscape shifts.

A Strategic Succession Management Template

1. Understand the implications of your strategy on talent needs.

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2. Develop a detailed profile of behavioral characteristics, job competencies, leadership expectations, knowledge, skills and experiences required for the future.
3. Design and facilitate a sustainable talent management process to select and develop the next generation of leaders and determine if key roles need to be filled with external candidates.
4. Customize development for incumbents, which includes strategically managed assignments, coaching, and targeted learning and development.
5. Design sustainability into the process to ensure it becomes a consistent part of your talent management framework and overall culture.

Creating Success Profiles for Leadership Positions

An essential component of strategic succession management is creating a detailed success profile. Success profiles consider an organization's overall culture and strategy, unique job responsibilities and challenges, and specific leadership dimensions required at the organization.

Warner L. Thomas, FACHE, president and CEO of Sutter Health, Sacramento, Calif., and previously president and CEO of Ochsner Health System, New Orleans, explained how he made succession planning a priority early on while leading Ochsner Health. Thomas implemented formal talent reviews and executive assessments for all C-suite positions. As a result, when it came time for him to leave Ochsner, there were several internal candidates that the board considered as his successor.

Louis A. Shapiro, an ACHE Member, who is transitioning out of the role of CEO at Hospital for Special Surgery, New York, explained that the first step of planning for his own successor was creating what he called a "key success criteria" for the new CEO that would reflect the organization's current situation and environment and where it needed to go in the future. The key success criteria, which is similar to a success profile, was used to identify Bryan Kelly, MD, HSS' current CMO, as the successor who would thrive in the position.

"My background as a long-tenured surgeon, scientist, innovator and executive with HSS enables me to assess opportunities in new, different ways, ensuring that we are meeting [the] needs of patients, the organization, and the communities and populations we serve," Kelly says. "This extends across the interconnected pillars of HSS: patient care, education, research and innovation, and people."

Practical Strategies for Strategic Succession Management

In addition to creating and assessing potential candidates against a future-focused success profile, there are three specific steps that organizations can take to build a pipeline for the next generation of leaders.

1. Identify potential leaders early. Leaders who make decisions about talent should always have their eye on developing a diverse, inclusive leadership pipeline. The success profile provides an established set of criteria to assess leaders and identify those who have the capacity for growth and ability to step into key leadership roles.

2. Design meaningful leadership development opportunities. Kelly White, who joined LifeSource as CEO in 2022, noted that her successful transition is due in part to the years she spent learning and developing her own leadership capabilities. For White, executive coaching and mentorship, taking opportunities to serve in a variety of stretch-leadership roles, and working on challenging projects earlier in her career gave her foundational experiences and confidence to step into a CEO role. Best-in-class organizations build their talent pipeline through continuous leadership development.
3. Communicate transparently with employees about the succession plan. Shapiro and other leaders at HSS began discussing leadership succession in 2021, two-and-a-half years before Shapiro would step down. According to Kelly, this gave Shapiro and the board plenty of time to prepare a strategic succession process, communicate the transition plan with leadership, and promote early support for Kelly.

In the rapidly changing healthcare industry, proactive, strategic succession management is critical for healthcare organizations. Staying ahead of the curve means identifying the success criteria for your organization, determining which leaders can be developed to take on future roles, and investing in leadership development opportunities to enable your leaders, and your organization, to thrive. ▲

Tracy L. Duberman, PhD, FACHE, is president and CEO of TLD Group, New York (tduberman@tldgroupinc.com).



Bhargavi Sampath



Kate Feske-Kirby



Kathy Gerwig

Decarbonization Starts at the Top

Leaders' critical role in reducing the carbon impact of quality patient care.

A growing number of healthcare leaders are driving initiatives to reduce their organizations' greenhouse gas emissions. They recognize the significant contribution their health systems' operations and supply chains make to a warming climate, creating both an opportunity and an obligation to mitigate the environmental impact of quality patient care. Healthcare leaders are uniquely positioned to reduce their health systems' carbon footprints and catalyze meaningful action across the sector.

Through effective governance systems; diverse stakeholder engagement, including environmental impact as a key dimension of quality and safety; and establishing more sustainable supply chain practices, healthcare leaders can steer their organizations toward more climate-conscious operations.

Establish a Governance System for Decarbonizing Care Delivery

A healthcare organization's decarbonization governance system provides an infrastructure for accountability, including setting targets, tracking progress and driving coordinated activity toward decarbonization goals. The governance system ensures that sustainability initiatives are embedded in the organization's

overall strategic planning and operations, promoting cross-functional alignment, collaboration and learning. The following actions can help establish a governance system for decarbonizing care delivery:

- **Set decarbonization goals.** Clear, measurable, science-based goals that commit to net zero emissions by 2050, with significant reductions by 2030, are foundational to addressing climate change. These targets encompass all aspects of care delivery and environmental sustainability, from energy use and waste reduction to supply chain management and investment portfolios. Institutional goals must cascade down to the facility, departmental and team levels, so each team understands its role and opportunities to advance the organization toward its net-zero targets.
- **Establish an executive-level team with accountability for the decarbonization strategy and implementation.** Clarifying accountability for setting and executing a net-zero strategy and operating plan will ensure continued prioritization and support. A comprehensive greenhouse gas emissions reduction strategy includes an outline of the key

initiatives, timelines and resources required to realize the established goals. Closely align these strategies with the organization's overall mission, vision and values, and encompass all levels of care delivery, from individual facilities to systemwide initiatives.

Healthcare leaders increasingly face the mandate to integrate environmental sustainability across their systems as a dimension of value and quality.

- **Measure emissions.** A measurement system is essential to track progress. Starting with a greenhouse gas emissions inventory in your health system, identify carbon hot spots and benchmark performance. The data can also support the translation of systemwide goals and objectives into work plans and dashboards and inform the prioritization of sustainability initiatives. The Agency for Healthcare Research and Quality's 2022 decarbonization primer provides a set of measures to prioritize tracking.

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Lead and Support Climate Initiatives

Enlisting the support of internal and external stakeholders is crucial for the success of decarbonization initiatives in healthcare. Executives must work together with staff, community partners, suppliers and others to gain buy-in, share knowledge and leverage collective expertise. This can be accomplished by the following:

- **Foster a culture of sustainability.** Executives across the system must actively promote sustainability initiatives and engage employees at all levels in reducing greenhouse gas emissions. This involves promoting awareness, education and training programs to increase staff understanding of the climate impacts of healthcare and clear guidance on how to act.
- **Engage the clinical workforce.** Clinicians are increasingly climate conscious and invested in sustainable care delivery. Healthcare leaders are well-positioned to broaden the definition of quality to integrate environmental considerations, in addition to cost, patient safety and health equity. This expanded view of healthcare quality can inform clinical decision-making by promoting evidence-based practices that consider the carbon impacts of different treatment options such as reducing unnecessary tests or procedures, shifting to low-carbon or reusable medical supplies and reducing or decommissioning desflurane use.
- **Partner with the local community.** Healthcare leaders can

partner with local community organizations to promote climate efforts, such as energy-saving initiatives, public and active transport use, and sourcing from local suppliers. Engaging with local partners can foster shared ownership and promote a culture of sustainability beyond healthcare systems. These partnerships also serve as a foundation for building resilient communities that can withstand infrastructure and social disruptions from extreme weather and other climate change effects. Because these are felt most acutely by historically marginalized communities, working closely with local partners in decarbonization demonstrates a commitment to health equity.

Leadership support of all stakeholders is crucial in setting the tone for an organization's commitment to a culture that prioritizes sustainability.

Embed Climate Action Into the Quality and Safety Strategy

Healthcare leaders increasingly face the mandate to integrate environmental sustainability across their systems as a dimension of value and quality. This requires considering the environmental impacts of care delivery in decision-making processes, evaluating the environmental performance of the organization and using this information to drive quality improvements.

- **Incorporate greenhouse gas emission metrics into the quality and safety dashboard.** By adding decarbonization indicators, such as energy consumption, desflurane use and fleet electrification rates, into existing quality

measurement frameworks, hospital leaders can establish sustainability as a core component of the organization's quality improvement efforts.

- **Integrate sustainability into quality improvement projects.** Hospitals regularly have a wide array of quality improvement initiatives underway. By ensuring that each chartered project accounts for environmental considerations, such as impact on greenhouse gas emissions, reducing waste or conserving resources, leaders can standardize the integration of sustainability into all aspects of the organization's quality improvement efforts.
- **Enlist infection prevention experts to champion sustainability initiatives.** Historically, patient safety and sustainability efforts have appeared to conflict. In practice, however, many interventions to decarbonize care delivery, such as reducing unnecessary testing and optimizing procedure packs, have improved patient safety and care quality. It is increasingly evident that leaders of infection prevention and sustainability must work in partnership to ensure that clinical practice is both safe and environmentally responsible.

By taking a holistic approach to integrating climate action into their quality and safety strategy, hospitals can ensure that reducing greenhouse gas emissions becomes an integral part of operations and contributes to the delivery of high-quality care in an environmentally responsible manner.

Establish a More Sustainable Supply Chain

The supply chain of a typical healthcare delivery organization accounts for about 50% of greenhouse gas emissions. To meaningfully reduce emissions across the healthcare sector, organizations must shift away from the traditional model—in which resources are extracted, processed, used, then discarded—toward a regenerative circular economic model in which materials are designed to have lasting value and continually cycled back into the economy.

Healthcare leaders can propel a shift in the supply chain toward a more circular economy by:

- Establishing clear expectations with and disclosure requirements for suppliers.
- Incorporating environmentally preferred purchasing (EPP) principles in procurement decisions.
- Implementing product stewardship programs such as reprocessing single-use devices.
- Forming power purchase agreements such as long-term renewable energy contracts.
- Partnering with group purchasing organizations to promote decarbonization across the supply chain.

These practices create economic, environmental and social benefits by reducing resource consumption, minimizing waste and promoting sustainable business practices.

Healthcare leaders play a pivotal role in driving decarbonization

efforts and reducing the carbon impact of quality patient care. These strategies serve to guide leaders in their efforts to establish more climate-conscious practices and operations, both within individual health systems and across the healthcare sector. ▲

Bhargavi Sampath is senior research associate at the Institute for Healthcare Improvement (IHI) (bsampath@ihi.org). Kate Feske-Kirby is research associate at IHI (kfeskekirby@ihi.org). Kathy Gerwig is a healthcare environmental stewardship advisor (kgerwigadvisor@gmail.com).

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Leslie D. Hirsch, FACHE

Addressing Social Determinants of Health

Saint Peter's puts Catholic mission into action every day.

Saint Peter's Healthcare System is one of New Jersey's few remaining independent, single-hospital health systems with a long history of humbly serving humanity, preserving the dignity of each life and providing safe, quality care to all. As a Catholic institution serving central New Jersey for over 100 years, addressing social determinants of health and healthcare disparities among the most vulnerable in the community is a top priority. We have made it our mission to proactively remediate key issues negatively impacting overall health and well-being, including food insecurity, housing instability, transportation access, exposure to domestic violence and substance use.

One of the health system's major initiatives to enhance access to patient care is Saint Peter's Family Health Center, located just minutes from the main hospital. The Family Health Center is one of the few of its kind in New Jersey and provides patients with access to comprehensive primary and

specialty care services. With 60,000 adult, pediatric and women's health visits annually, upward of 90% of the center's patients are covered by the Affordable Care Act, Medicaid, Medicaid Managed Care or the New Jersey Hospital Care Payment Assistance Program (Charity Care).

Intake surveys conducted by staff help identify specific social determinants of health that are more likely to put a patient at greater risk for potential health crises that could result in an ED visit or hospital admission. Staff then informs patients about the benefits programs for which they may be eligible, including assistance with food, childcare, paying bills, tax credits and more.

Saint Peter's has invested \$12 million into a modernization project of the Family Health Center to expand the organization's reach to 100,000 annual visits. Integrated in all new and existing services is a heightened focus on identifying social determinants impacting

health and enhanced efforts to work with community leaders to address these issues. The project will increase and upgrade health exam rooms to 75, from 49; add new laboratory services; expand behavioral health services; create a large physical therapy space; and introduce an on-site food market. The expansion project is scheduled for completion this year.

Saint Peter's focus on food insecurity includes collaborating with local farmers markets and providing vouchers to patients so they can obtain more nutritious foods. The health system has also partnered with a local food pantry to host food truck events, distributing hundreds of meals to patients and the community.

Lack of transportation is a major impediment to patients seeking care at the Family Health Center. Ridesharing services provide transportation to the center, as well as to the hospital and other off-site locations. Saint Peter's recently secured a grant to fund transportation costs to and from the center and to support a ride coordinator: someone who helps identify patients with a transportation risk factor and oversees ride request intakes. Grant initiatives will also include the use of translated outreach materials to accommodate diverse patient populations and staff training to better recognize and address social determinants of health

Saint Peter's by the Numbers

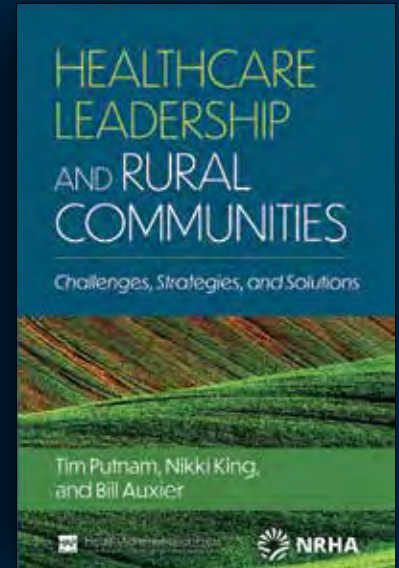
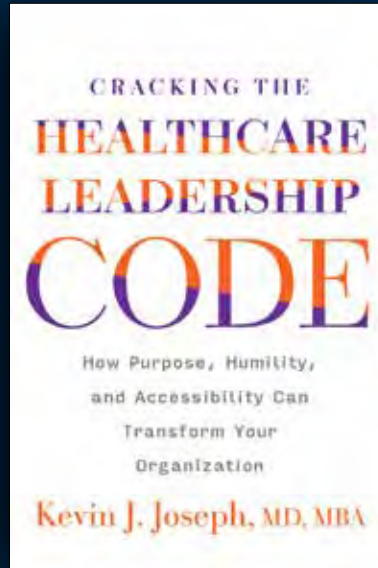
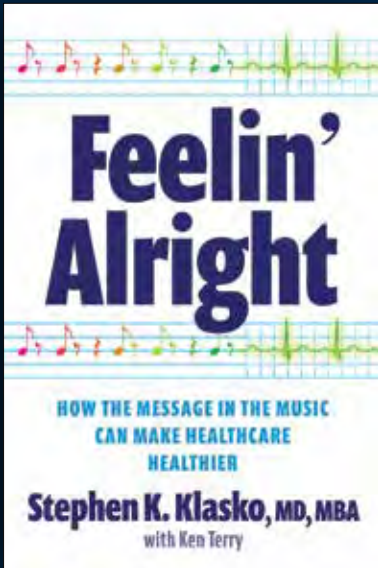
Location: New Brunswick (Pop.: 55,000), N.J., in Middlesex County (Pop.: 863,000).

Demographics: 42% white, 26% Asian, 22% Hispanic and 10% Black, according to the U.S. Census Bureau. One-third live below the federal poverty level.

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factors, connecting patients to resources needed for best health outcomes.

The Family Health Center offers primary and specialty care to adults and children, from newborns to young adults. It also provides obstetrical care to women—from prenatal care to intrapartum and postpartum care—as well as gynecological services.

The health system’s Pediatric Health Center, a service of The Children’s Hospital at Saint Peter’s University Hospital, administers over 26,000 immunizations, including COVID-19 vaccines. The center is a leader in Vaccines for Children, a federally funded program that provides vaccines at no cost to children who otherwise might not be vaccinated due to an inability to pay.

Saint Peter’s Family Health Center also houses two unique pediatric specialty

programs. The For KEEPS program, which stands for Kids Embraced and Empowered through Psychological Services, is a short-term, acute, partial-hospitalization unit offering high-quality mental health diagnoses and intensive treatment to children, ages 5 to 17, who are experiencing emotional and behavioral difficulties.

Services include individual, group and family therapy; academic instruction in collaboration with the child’s school district; and medication management. The program, licensed by the New Jersey Department of Health and Senior Services, has been cited as “a model for children’s partial hospital programs statewide.”

As one of the state’s four child protection centers, the Dorothy B. Hersh Child Protection Center is a state-designated child protection center, providing crisis intervention, child abuse assessments and referrals to community resources

throughout eight counties. The CPC has established working relationships with local offices of the Division of Child Protection and Permanency, prosecutors’ offices, and many local mental health providers, pediatricians, schools and police departments within the seven counties of the state’s central region. We are proud of the fact that our center remained open throughout the pandemic to provide care and resources to children and families in crisis, not only in our communities but also throughout the state.

At Saint Peter’s, we also are working to reverse the alarming trend of opioid use in Middlesex County through our Opioid Task Force, which includes ED physicians, nurses and pharmacists, law enforcement, addiction recovery specialists, and social agencies dedicated to educating and engaging the community. In the ED, Saint Peter’s clinical team connects patients in crisis—many of whom are experiencing an overdose—with recovery coaches, whose goal it is to help these individuals enter recovery.

Saint Peter’s also addresses the lack of housing or adequate housing through a multisector coalition of organizations and community members known as the New Brunswick Healthy Housing Collaborative. The Healthy Homes Project works to ensure all New Brunswick residents live in safe homes that facilitate healthy living. The team focuses on improving health outcomes by mitigating housing issues and identifying those neighborhoods with the greatest health and social disparities.

Dilapidated structures, poor heating, rusty plumbing, mold, dust and lead paint are all associated with adverse

Moving the Needle

Below are some of the results St. Peter’s is experiencing:

- Nearly 300 patients of the Family Health Center have been identified as being food insecure through Protocols for Responding to and Assessing Patients’ Assets, Risks and Experiences, a national standardized tool designed to equip health systems and their community partners to better understand and act on individuals’ social drivers of health.
- Approximately 300 rides per month are being offered to Family Health Center patients who have been screened and identified for the need based on income and availability of transportation to address accessibility and reduce the center’s no-show rate.
- Over 2,300 patients at the Family Health Center have been screened. Top issues identified are lack of social support, low income and issues related to employment.

health conditions like respiratory infections, asthma and lead poisoning. The collaborative uses a referral system to direct community members toward available resources with the common goal of promoting personal health and healthy living environments.

The hospital's community health services mobile health van is another way of bringing the hospital's extraordinary care services to wherever community need exists. Making healthcare convenient and accessible is critical to reducing the impacts of healthcare disparities, and the van travels to sites where services may be limited, including schools, retirement communities, daycare centers, homeless shelters, senior centers, public housing complexes, shopping centers, churches and corporations. Once on location, the van offers vaccinations, preventive screenings and assessments for blood pressure, cholesterol, blood sugar, vision, hearing and stroke.

As part of this outreach, Saint Peter's awarded 13 one-time grants to local organizations last year in support of their efforts to address social determinants of health. The grants, totaling \$500,000, will help improve the lives of those affected by food insecurity, mental health or lack of education and resources. The recipients included support for student scholarships at Catholic schools, food pantry ministries, mental health support for youth and young adults, and support for minority businesses and several faith-based organizations. The diversity of the organizations supported reflects Saint Peter's mission to serve individuals in the New Brunswick and greater Middlesex County region regardless of religious, ethnic or socioeconomic background.

Saint Peter's Healthcare System is open to all in the community, committed to serving the most vulnerable in a discrete and compassionate way, along with its focus on reducing the impact of social determinants on individual health and well-being. Saint Peter's is putting its Catholic mission into action on an everyday basis,

providing skilled, compassionate care along with education and outreach to promote proactive, preventive health-care measures to all. ▲

Leslie D. Hirsch, FACHE, is president and CEO, Saint Peter's Healthcare System, New Brunswick, N.J. (lhirsch@saintpetersuh.com).



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Lily J. Henson, MD, FACHE

Helping Great Physicians Become Great Leaders

Having credibility, being a team player and possessing patience are vital.

It's not uncommon for busy physicians to turn to their trusted partners—nurses—and instinctively know what we need from them in our care plans for patients, bloodwork and studies ordered, and referrals and follow-ups scheduled.

In leadership rarely does a decision have an immediate life-or-death impact, and careful and thoughtful vetting with a team allows for better decision-making. Learning patience with this process and engaging in it are important for physician leaders to be successful.

Undoubtedly, there are physician hospital chief executives who might long for those days when someone could just translate a vision into a smoothly running operation with perfect outcomes and no barriers or unintended consequences. Instead, they must consider the big picture and the data available and decide along with their teams what the strategic direction needs to be and work together to achieve agreed-upon goals.

Nationally, healthcare organizations led by physicians increased to 282 in 2021 from 90 in 2000, according to an analysis of the *American Hospital Association Guide to the Health Care Field 2021 Edition* by Carson F. Dye, FACHE, president and CEO, Exceptional Leadership LLC. How do we ensure that these physicians are ready and equipped to lead? Simply sending them to business school is not the solution.

Much has been written about the differences between what makes a great physician and a great leader. Physicians are used to making decisions quickly and executing plans to care for patients in an expeditious fashion. Leaders cogitate over situations with a team and often compromise to attain what is achievable within the constraints they have. It could be argued that physician leaders are a hybrid group with skills and characteristics that can flex to situations as warranted.

There are three critical components that make a successful physician leader: They need to be credible as clinicians; they need to know how to operate as a team with experts in other areas, such as finance and operations; and they need to have patience. They are now part of a decision-making process that may be

slower than what they are accustomed to in clinical practice. This is because decisions need to be made based on the overall good of the organization, instead of the physician's area. When decisions occur that may not be in line with the physicians' interests, the physician leader must fully support them.

Be Credible

For physician leaders to be successful, they must first be respected as a clinician by their peers and teammates. This may appear obvious, but unfortunately many aspiring physician CEOs have never even practiced medicine in their specialty or don't have an understanding of how a hospital or medical practice runs. It is not enough for physicians to come out of medical school, earn an MBA to gain the business knowledge they need and take the helm of a department without a real-world understanding of the work the department does. Physician leaders will be followed if they have a practical working knowledge of their specialty. Similarly, having experience in the basic medical staff leadership functions, such as peer review or credentialing, provides a foundation for a physician leader to then expand into operational hospital areas.

Be a Team Player

It is not expected that a physician leader be an expert in finance or

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marketing; there will always be experts in other areas to provide support. Understanding the contribution of these areas as part of the overall picture is critical, however, and being able to work collaboratively with these experts is important for running a healthy healthcare organization. Physicians sometimes believe they know all there is to know about how to staff an OR, or what makes a medical practice financially successful or how to market a product. More experienced physician leaders will realize there are nuances in operations and trends in payer and vendor contracting and market data from consumers that many physicians are not aware of. The need to defer to their colleagues in those arenas will help guide discussions on a broader level to make decisions based on overall healthcare trends and experience.

Be Patient

As part of the medical training process, physicians are expected to absorb a vast amount of knowledge, then trained to take clinical data points and process them quickly to generate a differential diagnosis. This list is narrowed based on diagnostic testing until a diagnosis is established, followed by a plan of action finely hewed based on specific individual data.

On a daily basis, physicians go through this process dozens of times as they see patients and swiftly make decisions about their care. This is very different than a day in the life of leaders, who have numerous scenarios they must address, few of which necessarily need to be decided upon quickly. For a front-line leader, routine tasks may need to be done, such as approving payroll or paid time off.

But for a higher-level leader who has strategic responsibilities, the steps required are identifying a situation, analyzing all the different ramifications associated with the situation, seeking out input and discussion with all subject-matter experts, and determining a path forward.

More experienced physician leaders will realize there are nuances in operations and trends in payer and vendor contracting and market data from consumers that many physicians are not aware of.

Although it can be said that this is not different from a clinical decision, in leadership rarely does a decision have an immediate life-or-death impact, and careful and thoughtful vetting with a team allows for better decision-making. Learning patience with this process and engaging in it are important for physician leaders to be successful.

Physician leaders must recognize they have a higher responsibility to their organization than just the specialty from which they come. As leaders, we must look at the big picture and make calculated decisions good for the overall organization rather than the areas we are responsible for. It is a balance to passionately advocate for the needs of our own department or specialty but also understand that the overall success of the organization outweighs any individual area's needs. As such, sometimes physician leaders have to set aside what they may desire for a decision that may be

better for the larger group. And after making a group decision, physicians must support and embrace the final plan as their own.

Representation in healthcare organizations by physician leaders is increasing. Having well-respected clinical leaders who understand how to work collaboratively with other healthcare leaders to make decisions for the overall good of the organization will enhance the success of our healthcare systems and help us provide better care for the communities we serve. ▲

Lily J. Henson, MD, FACHE, is CEO of the Piedmont Augusta (Ga.) Hub, with three campuses—Piedmont Augusta, Piedmont McDuffie and Piedmont Summerville—(lily.henson@piedmont.org).



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PEOPLE

AHA Recognizes Member-Led Organizations During Leadership Summit

Five organizations led by members of the American College of Healthcare Executives were among those recognized during the American Hospital Association’s July 2023 Leadership Summit in Seattle. Recipients were recognized with the following prizes and awards:

Circle of Life Award

Two programs at ACHE member-led organizations received AHA’s 2023 Circle of Life Award for their efforts in palliative and end-of-life care:

- Palliative Care Program, Johns Hopkins Bayview Medical Center, Baltimore, led by President **Jennifer Nickoles**.
- Center for Hospice Care, Mishawaka, Ind., led by Interim President/CEO, **Philip A. Newbold, FACHE**.

The Circle of Life Award honors hospital and palliative care programs that are ensuring equitable access to care; implementing nontraditional models

of care delivery and payment; fully integrating palliative care into a system of care or a community; making palliative care financially sustainable; developing meaningful measures and metrics to track progress; or partnering with payers, other providers, community groups and faith communities.

Equity of Care Award

The AHA’s Institute for Diversity and Health Equity awarded the 2023 Carolyn Boone Lewis Equity of Care Award to the following ACHE member-led organizations:

- Robert Wood Johnson University Hospital, New Brunswick, N.J., an RWJBarnabas Health facility led by CEO **Bill S. Arnold**, was selected as the 2023 Equity of Care Award, Emerging Winner. This award recognizes a hospital that is leveraging the Health Equity Roadmap resources to dismantle structural barriers in its care delivery system and the communities it serves.
- Monument Health Rapid City (S.D.) Hospital, led by President/

CEO **Paulette Davidson, FACHE**, was selected as the 2023 Equity of Care, Small/Rural Hospital Excellence Award Winner. This award recognizes a hospital or health system that has demonstrated excellence in advancing health equity in rural or small communities.

The Carolyn Boone Lewis Equity of Care Award annually recognizes outstanding efforts among hospitals and health systems to advance equity of care to all patients and to spread lessons learned and progress toward diversity, inclusion and health equity.

Quest for Quality Prize

Main Line Health, Bryn Mawr, Pa., led by President/CEO **John J. Lynch III, FACHE**, was named the 2023 recipient of the AHA’s Quest for Quality Prize. First awarded in 2002, the Quest for Quality Prize recognizes healthcare leadership and innovation in improving quality and advancing health in U.S. communities.

Main Line Health was selected for the prize based on its systemwide integration of quality, safety and equity, and for the governing and operating structures supporting these goals.

In Memoriam

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

Sean T. Lankford
Brentwood, Tenn.

Amanda Raffenaud
Casselberry, Fla.

Martha B. Smith, FACHE
Honolulu

Mortimer W. Zimmerman, FACHE
Boca Raton, Fla.

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PEOPLE

Freese Decker Named AHA Board Chair-Elect Designate

The American Hospital Association Board of Trustees elected **Christina (Tina) M. Freese Decker, FACHE**, president/CEO, Corewell Health, Grand Rapids, Mich., as its chair-elect designate. Freese Decker will be chair-elect in 2024 and become the 2025 chair of the AHA. Currently a member of the AHA Board of Trustees, Freese Decker served as an ACHE Regent for Michigan & Northwest Ohio from 2014 to 2017, and she was the 2013 recipient of ACHE's Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year.

ACHE Members Chosen as AHA 2024 Next Gen Fellows

Ten ACHE members are among the 43 emerging hospital and health system leaders who will participate in the 2023–2024 class of the AHA's Next Generation Leaders Fellowship. During the 12-month fellowship

program, participants will expand their knowledge on leading change, navigating the new healthcare environment, driving transformation, improving care delivery and developing operational strategies for success. The 10 ACHE members are:

Amanda M. Borer, FACHE, administrative director, neurosciences, Duke University Health System, Durham, N.C.

Michael R. Cureton, FACHE, chief administrative officer, Sutter Amador Hospital, Jackson, Calif.

Antionette Danvers, MD, director, family planning/director, residency program, Montefiore Medical Center/Albert Einstein College of Medicine, New York.

Anisa Jivani, system director, Strategic Equity Initiatives, Rush University System for Health, Chicago.

Lindsey M. Lehman, FACHE, vice chair, hospital operations, Mayo Clinic, Rochester, Minn.

Bailey K. Myers, director, operations, Mary Immaculate Hospital, Bon Secours Mercy Health, Norfolk, Va.

Alexandra (Lexie) Schwartz, RD, FACHE, vice president, operations, OSF HealthCare, Bloomington, Ill.

Karan P. Singh, MD, FACHE, FACEP, CMO, San Geronio Memorial Hospital, Banning, Calif.

Tri B. Tang, FACHE, vice president, administration, Atrium Health, Charlotte, N.C.

Ashton Wyrick, assistant director, government and community relations, Bryan Health, Lincoln, Neb.

LEADERS IN ACTION

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

Delvecchio S. Finley, FACHE Chair

American Hospital Association/Institute for Diversity and Health Equity, Accelerating Health Equity Conference
Minneapolis
(May 2023)

Karen F. Clements, RN, FACHE Governor

Maine Hospital Association
ACHE Breakfast Meeting, Summer Forum Conference
Rockport, Maine
(June 2023)

Michael O. Ugwueke, DHA, FACHE Governor

ACHE of Minnesota
ACHE MN Townhall: National and Local Updates
(June 2023)

ACHE STAFF NEWS

Following are promotion and new hire announcements.

Crystal Garrison promoted to coordinator, Development, Executive Office, from office services assistant, Department of Business Excellence.

Jacqueline (Jackie) P. Hunter, DC, ND, welcomed as vice president, Diversity & Inclusion, Executive Office.

Career Attainments by Race/Ethnicity: Position

Results by ACHE's Executive Office, Research.

In 2022, the American College of Healthcare Executives led the sixth in a series of studies conducted over the past 30 years comparing career attainments of healthcare executives by race/ethnicity. Questionnaires were sent to comparative samples of Asian, Black, Hispanic/Latino and white healthcare executives. Of the 9,416 ACHE members who were successfully sent the survey, 2,527 responded, yielding a 26.8% response rate. These responses were supplemented by a small number of responses from an earlier questionnaire pretest and a sample of executives provided by the National Association of Health Services Executives.

Among the many aspects of career progression examined in the survey was the proportion of executives in

the different racial/ethnic groups who had obtained senior leadership positions. The results are shown in the table below. At the time of the survey, 66% of white respondents held positions of vice president and above, while this proportion was 48% for Asian and Hispanic/Latino respondents and 43% for Black respondents. White respondents as a group were markedly older and Asian respondents as a group were markedly younger than members of other racial/ethnic groups. This may explain some of the variation in position attainment, but it does not appear to explain it all.

The study examined whether variation in respondents' current positions could be explained by differences in the roles they held

when they entered the healthcare leadership field. These results are also shown in the table. Variation in starting position does not appear to fully explain variation in current roles. The proportions of those entering the healthcare leadership field in positions of vice president and above were similar for members of the different racial/ethnic groups; 17% of Asian and Hispanic/Latino respondents, 16% of white respondents and 14% of Black respondents did so. Hispanic/Latino and white respondents were somewhat more likely to enter the field as department heads and somewhat less likely to have started in more junior positions than their Asian or Black counterparts.

ACHE thanks the executives who responded to this survey for their time, consideration, and service to their profession and to healthcare leadership research. ACHE also wishes to thank the National Association of Health Services Executives, the National Association of Latino Healthcare Executives, the Institute for Diversity and Health Equity and ACHE's Asian Healthcare Leaders Community Committee for their support of this study.

	Current Position				First Healthcare Leadership Position			
	Asian	Black	Hispanic/Latino	White	Asian	Black	Hispanic/Latino	White
CEO	10%	14%	14%	22%	4%	3%	3%	3%
COO/Senior Vice President	19%	14%	20%	21%	7%	5%	9%	5%
Vice President	19%	15%	14%	23%	6%	6%	5%	8%
Department Head	33%	38%	41%	26%	38%	41%	47%	48%
Manager/Supervisor/Program Director	3%	5%	3%	2%	12%	9%	11%	8%
Department Staff	13%	13%	6%	6%	29%	34%	23%	25%
Other	3%	3%	2%	3%	4%	3%	3%	3%
Total*	100%	100%	100%	100%	100%	100%	100%	100%
(N)	(271)	(503)	(256)	(1,194)	(269)	(505)	(256)	(1,188)

*Percentages may not sum to 100% due to rounding.

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The American College of Healthcare Executives Board of Governors met June 26–28. The Board concluded that ACHE is in a strong financial position, and growing value to members remains a high priority.

Strategic Plan

ACHE follows a three-year strategic planning cycle, and 2023 is year 2. In this year, the goal is to confirm the direction of the Strategic Plan. The Board reviewed the vision, mission and values and the Strategic Plan, making no changes for 2024–2026. In 2024, ACHE will conduct a deep dive to gather and analyze information to inform the 2025–2027 plan. Regents will play an active role in this process.

Business Update

The Board reviewed and approved financial statements for the current period and accepted ACHE's and the Foundation of ACHE's consolidated 2022 financial audit. ACHE received an unmodified (clean) audit opinion with no internal control concerns reported.

ACHE membership is experiencing modest growth as of April 30, with new member recruitment being particularly strong. The rate of Members passing the Board of Governors Exam is down from the prior year; however, there is a healthy pipeline of Members eligible to take the Exam this year.

Tactics are underway to increase the number of ACHE Fellows and Fellow applicants. A digitally focused

campaign will include a revamped web presence for the FACHE® credential, which includes video testimonials of Fellows and a robust email campaign to encourage targeted prospects to begin their FACHE journey.

The Board heard updates on the 2023 Congress on Healthcare Leadership and Virtual Leadership Symposium. This year was a record-breaking Congress, with a total attendance of 4,953. Overall satisfaction achieved a score of 4.57, which exceeds the 4.55 from 2022 and 4.29 in 2019. The Virtual Leadership Symposium held in May included 960 attendees, with an overall satisfaction score of 4.78. This exceeds the two prior Virtual Leadership Symposiums in the spring (4.67) and fall (4.56) of 2022.

An update was provided on Health Administration Press and initiatives to reinvent products, expand distribution channels and enhance marketing and sales strategies to deliver high-quality content to healthcare students, executives and organizations.

ACHE and the Foundation of ACHE Board of Governors Meeting Highlights

Strategic Imperatives

The Board had an in-depth discussion on the priorities established to

elevate the reach and impact of ACHE in achieving the Strategic Plan directives.

Technology Acceleration Plan

In our role as **Trusted Partner**, ACHE will commit to deepening engagement with members and the healthcare community through education, networking and career services to inspire and cultivate leaders to advance health. In doing so, ACHE will accelerate the use of technology to proactively meet the challenges of a rapidly changing environment and create unparalleled digital experiences for leaders.

ACHE is on an aggressive path to make key decisions regarding upgrades to core technology platforms and digital presence. This includes decisions that will allow ACHE to upgrade our website and content management system.

DEI Next-Level Strategy

In our role as **Catalyst**, ACHE will commit to leading for safety and equity. ACHE continues to prioritize its diversity, equity and inclusion strategy to support leaders and organizations in achieving equity to advance health.

A suite of resources for learning and development is being designed to amplify the impact of individuals and organizations across our profession. This includes creating a DEI narrative to drive awareness of ACHE's commitment to advancing DEI and health equity, and illustrate ACHE's commitment and future vision for DEI in a way that inspires pride among ACHE members, engagement from prospective members and demonstrates the value of DEI.

Effort is also being directed at developing a DEI competencies assessment tool for individuals and related blueprint for C-suite leaders to effectively foster inclusive cultures and lead through a lens of equity.

As part of the Fund for Healthcare Leadership, Chair Delvecchio S. Finley, FACHE, and Chair-Elect William P. Santulli, FACHE, are leading the \$1 Million Campaign for Healthcare Leaders of Tomorrow. This campaign highlights ACHE's unique opportunity to help address the well-documented gap between the diversity of healthcare organization C-suites and the diversity of the communities they serve. This campaign also paves the way to a bolder,

brighter future for our field by supporting new scholarships to support diverse leaders in acquiring the skills and training needed to advance and lead.

The board also was informed that Jackie P. Hunter, DC, ND, was named vice president, Diversity and Inclusion, Executive Office. In her role, Hunter will further ACHE's strategic DEI efforts, and you can expect to hear more about her priorities going forward.

Strengthening the ACHE/Chapter Partnership

In our role as **Connector**, ACHE will commit to growing our professional community across the healthcare

continuum by leveraging our partnerships with chapters and other organizations. Work continues to define an approach to evolve the ACHE/chapter partnership to provide meaningful membership experiences and advance the mission and vision of ACHE. After reviewing the current state of the partnership, the Board engaged in discussion about the future of how ACHE can support chapters. Best practices that ease the administrative burden on chapters were prioritized, and active consideration is being given to pilot approaches.

All in all, the Board noted it was a productive meeting and ACHE is well positioned for the future. ▲



Develop a Postgraduate Fellowship

Creating future leaders benefits you, your organization and the profession. It's an opportunity to **teach others**, **develop talent** and **invest in the next generation**.

Building a program is easy. ACHE's Fellowship Resources will assist you, and RoseAnne M. Filicicchia, marketing coordinator, is available to answer your questions at rfilicicchia@ache.org.

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



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

Leeza L. Bacon, DHA, FACHE, department chair/associate professor, Northwood University, Midland, Mich., received the Outstanding Faculty Award from the Regent for Michigan & Northwest Ohio.

D. Michael Diener, FACHE, president, Adena Regional Medical Center, Chillicothe, Ohio, received the Outstanding Service Award from the Regent for Ohio.

Larry W. Gray, president, Baptist Health Louisville (Ky.), received the Senior-Level Healthcare Executive Award from the Regent for Kentucky.

James V. Guliano, FACHE, senior vice president, operations/chief clinical officer, Ohio Hospital Association, Columbus, Ohio, received the Senior-Level Healthcare Executive Award from the Regent for Ohio.

Adam C. Haas, administrative assistant II, Cleveland Clinic, received the Outstanding Service Award from the Regent for Ohio.

Peter J. Karadjoff, FACHE, CEO, Quadruple Aim Consulting, received the Senior-Level Healthcare Executive Award from

the Regent for Michigan & Northwest Ohio.

Brian G. Lane, FACHE, president/CEO, Center for Health Affairs & CHAMPS Healthcare, Cleveland, received the Senior-Level Healthcare Executive Award from the Regent for Ohio.

Sean Leahy, vice president, business development, Gotham Companies, New York, received the Early Careerist Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Jonathan Lehr, account executive, Trane Technologies, Davidson, N.C., received the Early Careerist Healthcare Executive Award from the Regent for Kentucky.

Prateek Mansingh received the Student Award from the Regent for Connecticut.

Lewis W. Marshall, MD, JD, FACHE, CMO, NYC Health + Hospitals/Lincoln, received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Angela Mattie, JD, professor/chair, healthcare management, Quinnipiac University, Hamden,

Conn., received the Senior-Level Healthcare Executive Award from the Regent for Connecticut.

Matthew R. Orsey, manager, quality and medicine service lines, Beaumont Health, Southfield, Mich., received the Early Careerist Healthcare Executive Award from the Regent for Michigan & Northwest Ohio.

J. Michael Parnell, PhD, RN, FACHE, CEO, UnitedHealthcare Community Plan of Mississippi, Jackson, Miss., received the Senior-Level Healthcare Executive Award from the Regent for Mississippi.

Lindsey B. Pauline, FACHE, director, Nationwide Children's Hospital, Columbus, Ohio, received the Leadership Award from the Regent for Ohio.

Zakiya Robinson, FACHE, system director, nursing finance, Premier Health, Dayton, Ohio, received the Early Careerist Healthcare Executive Award from the Regent for Ohio.

Tina M. Sanzone, RN, vice president, access and navigation, Akron (Ohio) Children's Hospital, received the Leadership Award from the Regent for Ohio.

Kyle Underwood, project manager III, Cleveland Clinic, received the Early Careerist Healthcare Executive Award from the Regent for Ohio.

Robert M. Weiss, regional business operations manager, Hartford (Conn.) Healthcare, received the Early Careerist Healthcare Executive Award from the Regent for Connecticut.



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Asian American healthcare executives face distinct challenges and opportunities. Explore them together, as a community.

Asian Healthcare Leaders Community

Enhance the representation of lesbian, gay, bisexual, transgender and queer individuals in healthcare while working to improve LGBTQ+ patient care.

LGBTQ+ Healthcare Leaders Community

Connect, collaborate and discuss challenges directly with peers in (or transitioning into) a management role.

Physician Executives Community

Advance your skills, grow your business and find professional support with other consultants at every professional level.

Healthcare Consultants Forum*

Exchange ideas, share best practices and gain valuable tools, insights and resources from other healthcare CEOs.

CEO Circle*

**This group requires an additional membership fee.*

Engaging Members

Michigan/Ohio and California share how they involve their members.

The following are unique events the Midwest Chapter of the American College of Healthcare Executives (Michigan, Ohio) and California Association of Healthcare Leaders held during the past several months.

Leading as Your Best Self

Nearly 150 emerging and executive leaders from The Midwest Chapter of the American College of Healthcare Executives took part in the chapter's biannual MCACHE Emerging Leaders Summit in Detroit, focusing on the theme "Leading as Your Best Self."

Two physicians from Henry Ford Health, who also serve in that role for the Detroit Pistons, kicked things off with a keynote address. They discussed how to be the best version of yourself

personally and in your career; outlined holistic approaches to physical, mental and social well-being; and described how concepts of physical and mental preparedness in sports performance can be used in a professional setting.

Angela DeLaere, FACHE, the chapter's president, and president and CEO, Visiting Nurse Association and Bluewater Hospice, Port Huron, Mich., moderated a discussion with the physicians following their keynote. "The synergies between the speakers expressed how they bring their best self to work every day and how they work as a team in a role of high demands," says DeLaere.

Attendees also participated in breakout sessions that included a

leadership/personality assessment, how to optimize your personal brand online and an interactive case study on dealing with multiple priorities as a new leader. A tour of Ford Field, home of the Detroit Lions, followed.

To close out the summit, attendees enjoyed a panel discussion titled "What Does it Mean to Bring Yourself to Work?" Panelists included a distinguished group of healthcare leaders who gave insight into tips for bringing your best self to work and methods for overcoming adversity and stressful situations. The panelists spoke on how to remain present in the moment, support the mission at hand and deliver quality outcomes for their teams, all while being a servant leader.

Throughout the summit, attendees could get their resumé reviewed and headshot taken. The event concluded with networking over drinks and appetizers.

The summit was well received by the local chapter board and the attendees, with many commenting that it was one of the largest and most successful events the chapter has hosted in years.



The Midwest Chapter of the American College of Healthcare Executives took part in the chapter's biannual MCACHE Emerging Leaders Summit in Detroit.

Attendees are eagerly looking forward to attending the next summit in 2024. The event was the culmination of a yearlong effort by its planning team and showcased the power and potential of Metro Detroit's young professionals in bringing healthcare organizations together.

Implementing Clinical and DEI Programming

California Association of Healthcare Leaders' Clinical Leadership Committee and Justice, Equity, Diversity and Inclusion Committee create opportunities for education, collaboration, professional growth and networking.

The Clinical Leadership Committee provides practical tools for clinician leaders to decrease health disparities in their organizations. The committee chair presented on the topic "Moving From Person-Centered to Equity-Centered Care: Strategic and Practical Implementation of EID in a Large Healthcare System to Improve Health Disparity Outcomes" at the 2023 Congress on Healthcare Leadership. In a collaborative effort with the Member and Volunteer Growth committees, CLC presented an abbreviated version

of this presentation to new chapter members. The chapter prioritizes justice, equity, diversity and inclusion initiatives to improve overall healthcare disparities. CLC will also be collaborating with the Higher Education Network Committee to optimize recruitment and engagement of clinician students (like medical and nursing students), while providing educational events that will expose them to the business and leadership side of medicine early in their careers.

The chapter's leadership believes healthcare leaders have a responsibility to consider how clinical care delivery systems and patient outcomes are affected and can be improved by considering environmental, social and corporate governance. The Clinical Leadership Committee hosted a Virtual ACHE Face-to-Face Education credit panel, "Improving the Health Status of Your Community: Climate Change & Population Health." Attendees learned how ESG affects clinical care delivery and next steps on how to improve clinical outcomes using this model.

The Justice, Equity, Diversity and Inclusion Committee hosted a Virtual

Face-to-Face Education credit event to make the business case for DEI work, and there are plans for a series that will focus on how to implement a program. The series will include case studies of organizations at different points in their journey and strategies for building momentum. The goal is to provide DEI offerings that can help individuals and organizations at any stage of their journey.

Another area of focus is to determine what progress needs to look like for the diversity composition of the chapter's membership and what committees need to further justice, equity, diversity and inclusion initiatives.

The chapter surveyed members to identify areas that are important to them. The results and feedback will reveal members' priorities so programming and support can be organized to meet these needs. ▲

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





Briton



Chinn



Jackson



Ratnasamy



Senker



Wharton

Juan Awad to market leader, Palm Beach, Martin, St. Lucie, Okeechobee and Indian River Counties (Treasure Coast), Florida Blue, Jacksonville, Fla., from hospital CEO, Ochsner Health, New Orleans.

Krisianna Bock, FACHE, to principal, HKS, Los Angeles, from vice president.

Emily Briton to president, MedStar Montgomery Medical Center, Olney, Md., and senior vice president, MedStar Health, Columbia, Md., from COO/senior vice president, MedStar Washington Hospital Center, Washington, D.C.

William A. Chinn, FACHE, to president, Penn Highlands DuBois (Pa.), from COO, Ochsner Health—Baptist Hospital, New Orleans.

Brian C. Doheny, FACHE, to COO, Lucet, Overland Park, Kan., from vice president, Medicare Trend and Innovation, Humana, Louisville, Ky.

Dave K. Dookeeram, FACHE, to COO, Pager, N.Y., from president, diagnostics, and chief of staff, DispatchHealth, Denver.

Marcus Jackson Sr., FACHE, to COO, Medical City Las Colinas,

Irving, Texas, from vice president, operations/co-ethics compliance officer, Medical City Arlington (Texas).

Gregory T. LaFrancois, FACHE, CPA, to president, Eastern Maine Medical Center, Bangor, Maine, from president, Northern Light A.R. Gould Hospital, Presque Isle, Maine.

Casey T. Liddy, FACHE, to president, OhioHealth Berger Hospital, Circleville, Ohio, from interim president.

Kevin J. Matson, FACHE, to vice president, regional hospitals, Northeast Georgia Health System, Gainesville, Ga., from interim president, Habersham Medical Center, Demorest, Ga.

Corbi D. Milligan, MD, FACHE, FACP, to CMO, Memorial Health, Savannah, Ga., from CMO, HCA Florida Trinity (Fla.) Hospital.

Christopher J. Munton, FACHE, to CEO, Wilson (N.C.) Medical Center, from CEO, Harris Regional Hospital, Sylva, N.C., and Swain Community Hospital, Bryson City, N.C.

Philip Okala, FACHE, to COO, Tufts Medicine, Burlington, Mass.,

from system president, City of Hope, Los Angeles.

Elmer B. Polite to president, Eastern Division, Lifepoint Health, Brentwood, Tenn., from chief financial executive, Midlands market, Prisma Health, Columbia, S.C.

Sudandra Ratnasamy, FACHE, to CEO, Twin County Regional Healthcare, a Duke LifePoint Hospital, Galax, Va., from market CEO, Tampa/St. Petersburg, ScionHealth (Kindred), Louisville, Ky.

Thomas J. Senker, FACHE, to president, MedStar Union Memorial Hospital and MedStar Good Samaritan Hospital, both in Baltimore, from president, Medstar Montgomery Medical Center, Olney, Md.

Mathew G. Timmons, FACHE, to senior vice president/COO, Children's Hospital New Orleans, from interim chief administrative and chief strategy officer.

Monica N. Wharton, JD, FACHE, to COO/executive vice president, Methodist Le Bonheur Healthcare, Memphis, Tenn., from chief administrative officer.

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