

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

JULY/AUG 2022
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Optimizing Operations and
Capacity—Despite Personnel
Shortages

40

Can Term Limits Increase
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Cover Story

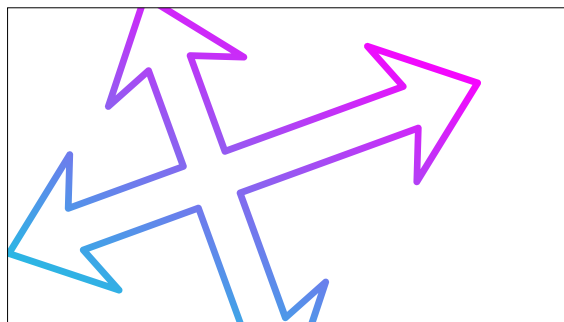
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Fresh, Exclusive Content

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

Inside the Air Traffic Control Function of a Florida Hospital

Much like an air traffic controller limits bottlenecks in the air, staff at Sarasota (Fla.) Memorial Healthcare System do the same at their facilities, continually monitoring admissions, surgeries, ED visits, discharges and other data as they work closely with unit leaders to determine staffing needs.



Recent *Healthcare Executive* Podcasts

You can find the following interview at **HealthcareExecutive.org/Podcast** or search for “Healthcare Executive” in Apple Podcasts or iTunes:

Career Challenges and Solutions

On Page 38 in this issue of *Healthcare Executive*, Natalie Lamberton, FACHE, CEO, Denver Springs, Denver, writes about how to rebound from stressful career situations.

You can also listen to a podcast, “The New Challenges of Early-Career Healthcare Leaders,” with Lamberton and Laurie Baedke, FACHE, FACMPE, as they discuss their book *The Emerging Healthcare Leader: A Field Guide* (Health Administration Press, 2018).

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Emma O'Riley

Expanding Access While Pursuing Efficiencies

Of all the ways healthcare has evolved in the past two-plus years, one of the more encouraging ones is how leaders are addressing disparities in care in their communities. By prioritizing health equity, organizations are making strides in providing care to vulnerable populations that historically have been marginalized.

Our cover story, “Opening More Doors: Increasing Access to Care” (Page 8), offers examples of how leaders and organizations are accomplishing that. From deploying health vans into the community during the pandemic to integrating mental health services at a primary care clinic, hospitals and health systems are employing new strategies and tactics to reach people where they are and when they need it.

As care is delivered to more patients, leaders also must determine how to keep their hospitals and health systems functioning at peak efficiency, despite workforce shortages that have left front-line staff stretched thin. Our second feature, “Optimizing Operations and Capacity—Despite Personnel Shortages” (Page 18), explores some of the creative solutions leaders are using—such as pooling resources, automating processes and investing in technology—to keep their organizations running as close to normal as possible during an increasingly challenging time.

This issue also includes the *Ethics Self-Assessment* (Page 66), which is used to evaluate leadership and ethics-related actions and address potential red flags identified in the process. Each year, ACHE's Ethics Committee reviews and either reaffirms or revises the Ethics Self-Assessment; no changes were made to it this year.

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

Correction notice: In the “Executive News” section of the May/June 2022 *Healthcare Executive*, we incorrectly listed ACHE Member David A. Cauble as having been president/CEO of Sky Lakes Medical Center, Klamath Falls, Ore., when the organization received the 2021 American Hospital Association Rural Hospital Leadership Award in February 2022. Cauble did not assume the role of president/CEO, Sky Lakes Medical Center, until March 2022. We apologize for the error.

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Deborah J. Bowen,
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Driving Socially Responsible Leadership

Progress starts through partnering with the board.

Focus on environmental, social and governance, or ESG, issues has become more prevalent in recent years, driven largely by climate change, calls for social justice reform and inequities exposed by the pandemic. Healthcare organizations innately hold a deep commitment to socially responsible values, but stakeholders today expect more—and in ways that can affect organizational reputation and community trust.

According to the 2022 Edelman Trust Barometer, an annual global trust and credibility survey, societal leadership is now a core function of business. CEOs are expected to lead and shape policy on such topics as global warming, wage inequity and other ESG issues. Meanwhile, a 2021 PricewaterhouseCoopers Health Research Institute consumer survey found that nearly two-thirds of respondents would view an organization more positively if it was taking action to address social determinants of health.

It's true that by the nature of our work, our mission-driven efforts are inherent in all that we do. Yet prioritizing our organizations' work on ESG is increasingly vital to patients, and strengthens both sustainability and financial performance. As with any initiative, engaging the governing board on these priorities is an essential step. Here are a

few thoughts about how leaders can partner with their boards on this topic.

Ensure ESG is part of the organization's strategy. Securing the board's commitment to these issues can be a first step. Building awareness and prioritizing ESG in board discussions can generate buy-in, paving the way to embedding it in the organization's mission, purpose and strategy, and driving it through all areas of the business—such as environmental footprint, supply chain practices, and recruitment and retention. Regular progress reports can keep the board informed to hold leaders accountable and include ESG as part of strategy and risk considerations. By ingraining ESG into the organization's core, board members can be well-positioned to champion it through ongoing guidance, advice and support.

Disclose progress on ESG issues. Of the top 50 health systems by revenue, only 24% publicly report their ESG efforts, according to a recent Guidehouse analysis. Yet a 2021 report by KPMG states that more healthcare stakeholders, including regulators and investors, are requesting that organizations disclose ESG criteria and metrics. For example, the U.S. Internal Revenue Service requires nonprofit hospitals to demonstrate benefit by assessing community health needs every three years to maintain their tax-exempt status.

Leaders can work with the board to review performance on initiatives and establish reporting systems that inform stakeholders about the return on investment such as the impact made on health outcomes. This can be accomplished by expanding an organization's annual report to include progress on ESG priorities, or developing a separate sustainability report, for example.

Diversify the boardroom: Strong environmental sustainability strategies have equity, diversity and inclusion at the center, and that starts with the board. Finding the right composition and structure, one with a balance of relevant backgrounds, experience and skills, can generate healthy dynamics and relationships that lead to innovative ideas. When selecting new members, choosing candidates who support and view the organization's ESG priorities as opportunities can propel those focus areas forward. A diverse board also fosters equity, diversity and inclusion at all levels, from the C-suite to hourly workers, which aligns fully with any ESG strategy.

How boards allocate oversight of ESG priorities will depend on the organization, whether it be by the full board, existing committees or a newly formed ESG-specific committee. There is no one-size-fits-all approach to it. What is universal, though, is that ESG and sustainability are new imperatives of healthcare organizations, steeped in the ongoing mission of patient care. Partnering with—and preparing—boards to engage on these priorities can broaden that mission in ways that promote socially responsible leadership. ▲

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

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Increasing
Access to Care

by Susan Birk

The uneven impact of COVID-19 on communities of color and other marginalized populations in the United States threw the issue of healthcare disparities into sharp relief when the pandemic began. The amplified evidence of long-standing imbalances in social determinants of health and access to care raised the country's collective consciousness.

As that happened, healthcare executives' perceptions began to be transformed as well.

That's a good thing, because healthcare organizations face the ongoing work of ensuring access to care for their most vulnerable patients as they continue to grapple with ongoing pandemic-related hurdles. They need all the insight into disparities they can get.

A Wake-Up Call for Providers

And they're learning. More healthcare organizations have begun collecting data to pinpoint the gaps in their communities, observes Kedar S. Mate, MD, CEO, Institute for Healthcare Improvement.

For many, the insights gleaned from the analytics have offered a wake-up call. "People don't like to see that they're treating populations inequitably. No one likes to have that happen on their watch," Mate says

The disparities so vividly displayed during the pandemic catalyzed an epiphany of sorts among healthcare leaders.

Pre-COVID-19, IHI surveys showed health equity to be near the middle or bottom of healthcare executives' spectrum of priorities, according to Mate. Responses to disparities initiatives were favorable but not overwhelming.

The crisis crystalized their focus. The percentage of healthcare leaders who named disparities as one of their organization's top three priorities more than doubled from 25% to 58% between 2019 and 2021. Disparities ranked nearly as high as safety, which 59% of respondents named a top three priority. "Health equity was the biggest delta in that two-year window," Mate says. "The pandemic and the racial justice movement generated a crucible for the will to work on this issue."

The American Hospital Association reports similar findings. Although the AHA Institute for Diversity and Health Equity's last biennial survey, completed in 2019, revealed a strong desire among health systems to tackle equity, the data suggested organizations were doing more planning than executing, says Priya Bathija, the AHA's vice president of strategic initiatives.

Enter the new coronavirus, which thrust inequities into the spotlight. Though data from the 2021 survey won't be available till the end of 2022, "in speaking with leaders about how their work has changed over the past two years, we're seeing hospitals start to close that gap between planning and doing," Bathija reports.

Denver Health: An Equity Innovator

For Denver Health, there never has been a gap between planning and doing. As one of the state's largest providers of Medicaid services, Denver Health exists to serve vulnerable patients, 90% of whom live at 200% or less of the poverty level.

The organization runs a 555-bed flagship hospital as well as 10 federally qualified community health centers and 19 school-based clinics in the city's poorest neighborhoods.

Denver Health has used its experience in dealing with social risk factors to serve as a powerful safety net during the pandemic, and as an incubator for innovation.

"It's hard for people to connect to large institutions, so meeting them where they are, in the settings that are important to them, is a critical part of our strategy," says CEO Robin Wittenstein, EdD, FACHE.

Denver Health had difficulty maintaining access to care as COVID-19 ramped up and the provider was forced to close its clinics. In response, it created a service that deploys three mobile health vans to deliver primary care, COVID-19 testing and vaccines.

The program leverages connections with churches, mosques, libraries, recreation centers and homeless shelters

to reach patients. Public health workers also connect with homeless individuals on the street.

"It's hard for people to connect to large institutions, so meeting them where they are, in the settings that are important to them, is a critical part of our strategy."

Robin Wittenstein, EdD, FACHE
Denver Health

"These efforts are a powerful way of demonstrating to patients that, in a moment of crisis, healthcare sees their challenges and is willing to come to them," she says.

Denver Health kept its well-child clinics open so newborns and toddlers could continue to receive immunizations and care.

"Keeping our finger on that pulse is critical, even in the face of COVID," she says.

Other projects include:

- A hypertension management pilot project with the Denver Housing Authority that provides virtual healthcare via a telemedicine suite in a subsidized residence for patients who do not have access to electronic devices. Patients receive a Bluetooth-enabled blood pressure cuff and blood pressure education.
- An initiative to address lower immunization rates among Black children stemming in part from distrust of vaccines within the Black community. Denver Health is using its large dental care program as a vaccination site and conduit for discussions with parents.

"We need to understand where we touch patients and build opportunities to close the gaps into every one of those encounters," Wittenstein says.

As the hospital was stretched to capacity caring for the sickest COVID-19 patients, it also created a nationally recognized virtual hospital-at-home program for low acuity patients.



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Patients were given a package of tools to care for themselves at home and received regular calls from physicians and nurses. If their health began to decline, patients were immediately brought by ambulance to the hospital. The program has served 1,300 patients.

“Care can be retooled to meet the changing needs of patients in the most appropriate setting,” Wittenstein says. “Keeping patients out of the hospital should be the goal of every health system in the country.”

Memorial Community Hospital and Health System: Leveraging The Small-Town Advantage

With a minority group population of 5.3% and a poverty rate of less than 10%, Memorial Community Hospital and Health System’s demographics differ from those of Denver Health, but the two organizations share a common belief in the power of community partnerships.

When the COVID-19 vaccine became available and the Blair, Neb.-based provider realized that none of its clinics would be large enough to handle the volume of patients getting it, an employee suggested reaching out to an athletic training facility occupying the campus of a local community college that had closed 10 years earlier.

The facility had an unused gym with the perfect layout, including a large hallway. MCHHS used the site to deliver more than 900 vaccines daily.

“This is the value of community partnerships,” says Manuela Banner, RN, FACHE, president and CEO. “This facility had nothing to do with healthcare, but vaccinating our patients would’ve taken a lot longer without this access.”

“Our key strategy is talking to all the community groups we can. When it comes to medical care, being in a rural area has its advantages. A lot of times our connections and patients are our neighbors and family members.”

Manuela Banner, RN, FACHE
Memorial Community Hospital and Health System

Initially, MCHHS used its EHR to stratify high-risk patients and cared for many of them through virtual visits or by phone. “Once we learned more about COVID safety, we encouraged them to come in because we didn’t want them to miss their preventive care,” she says.

To maintain access to care during COVID-19 without jeopardizing safety, MCHHS saw healthy patients in the morning and sick patients in the afternoon to keep the two populations separate.

Still classified as a rural provider despite its location only 20 min-

utes from Omaha, MCHHS serves a community of 27,000 patients spanning two counties. The relatively young, affluent population makes the service area something of an anomaly among rural providers.

MCHHS’s most recent community health needs assessment revealed behavioral health and substance abuse as the top unmet needs, with lack of transportation for these patients following close behind. Within the school population, bullying (electronic and physical), alcohol use and vaping emerged as significant concerns.

To address these issues, MCHHS is developing an integrated mental health service at its primary care clinic. The goal is to increase access to behavioral healthcare for youth and adults by locating a behavioral health professional in the same place where patients see their family doctor.

“An integrated service removes some of the stigma of going to a counselor,” explains Banner. The model also gives family practitioners real-time access to a behavioral health professional if they identify a patient in need.

While the integrated mental health service is still in the planning stages, an outpatient on-site group therapy program led by a nurse case manager specifically for older adults dealing with loss, depression and other mental health issues has gotten off the ground. Psychiatric care via telehealth is available as needed.

Most participants come to the program via a robust referral process, and community outreach plays a vital role, with connections made through the Rotary Club, church groups and lunch-and-learn events at the hospital.

“Our key strategy is talking to all the community groups we can,” Banner says. “When it comes to medical care, being in a rural area has its advantages. A lot of times our connections and patients are our neighbors and family members.”

Mercy Medicine Free Clinic: A Medical Home for the Indigent

Like Denver Health, Mercy Medicine Free Clinic, Florence, S.C., exists to ensure access to care for the most vulnerable. One of 39 members of the South Carolina Free Clinics Association, the organization was chartered in 1994 to provide a free medical and dental home for the indigent, low-income and prison-release populations ages 18–64 in Florence, Williamsburg and Marion counties.

At any given time, 20% of the population qualifies as homeless.

Unlike Denver Health, Mercy Medicine Free Clinic is privately funded and does not accept federal third-party payers.

“Our niche is patients with virtually no income or those who fall below 200% of the poverty threshold,” says Wayne Jackson, FACHE, executive director. In addition to providing medical and dental care, the clinic takes referrals of patients lacking a medical home who seek nonemergent care in the ERs of Florence’s two medical centers.

“The case managers in those ERs have become good at identifying patients who meet our criteria. Treating these individuals with our private funding reduces bad debt for these organizations,” Jackson says.

Core providers consist of an internal medicine physician medical director, three nurse practitioners and a team of volunteer clinicians, including two nephrologists, four dentists, a pain management specialist, a physical therapist and a dietician. In addition to primary care, the clinic offers mobile mammographies twice yearly and mobile behavioral healthcare through the South Carolina Department of Mental Health’s Highway to Hope Project.

To address access to care challenges, Denver Health created a service that deploys three mobile health vans to deliver primary care, COVID-19 testing and administer vaccines.



Photo Credit: Denver Health

In 2021, Mercy Medicine provided more than 1,100 office medical visits and saw 250 unduplicated patients—a drop of about 50% from before the pandemic. Apprehension among unvaccinated patients and cutbacks in the city bus service had a chilling effect, Jackson notes.

When the vaccine became available, Mercy Medicine served as a vaccination center in cooperation with the Medical University of South Carolina. To tackle some people's distrust of the vaccine, the clinic employed a strategy of culturally appropriate education and encouragement. "Our medical numbers are edging up," Jackson reports.

Though patients must meet income criteria to receive care at the clinic, the massive job losses that occurred during the pandemic presented a unique circumstance. In response, the clinic created a program that relaxed the income requirements for participation, serving as a one-year stopgap for people who unexpectedly lost their jobs.

The clinic has also worked with the University of South Carolina School of Public Health on the development of a methodology to teach indigent patients how to ask questions of providers during appointments to maximize the benefits they receive from the visit and help improve outcomes. Plans are underway to introduce the methodology for implementation statewide.

A Lasting Strategy

The organizations profiled here are committed to opening more doors to care during the pandemic and beyond. And IHI's Mate believes their care access strategy can change the way healthcare is delivered and vulnerable populations are treated in the U.S.

Mate points to signs that the commitment to advancing health equity and increasing access to care could last. One is the fact that public support runs deep. The new awareness of healthcare disparities has reverberated through all facets of society.

"For the next few years, we're going to be talking a lot about equity, and some of that will stick," Mate says.

To make sure it does, Mate and other public health leaders have called for the creation of a Quintuple Aim that adds advancing health equity to healthcare's Quadruple Aim of better population health outcomes, better patient experiences, lower costs and workforce well-being.

"The case managers in those ERs have become good at identifying patients who meet our criteria. Treating these individuals with our private funding reduces bad debt for these organizations."

Wayne Jackson, FACHE
Mercy Medicine Free Clinic

This goal is needed because most of healthcare's challenges in achieving the Quadruple Aim stem from lack of attention to the equity dimensions of healthcare, Mate and his colleagues argue in a *JAMA Viewpoint* article published Jan. 21, 2022.

Since providers' ability to move toward value-based care depends largely on success around the four aims, integrating equity into all aspects of that work makes sense in terms of caring for patients and of economic survival, Mate says. Advancing equity is good for people and good for the business of healthcare, too.

"There's no single playbook for advancing health equity," Bathija says. "It's important for leaders to focus first on understanding what's happening in their communities. We'll never be done, but we can continue to understand, test, improve and mature."

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



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Building a Better Supply Chain

A standardized approach and valuable collaboration yield positive results.

“You can have the best plans in the world, but if the partner that supports those goals falls short, the plan doesn’t mean anything.”

—David Bueby

Corporate Vice President,
Supply Chain Management
McLaren Health Care
Grand Blanc, Mich.

A strong supply chain strategy is essential for health systems large and small, as organizations seek greater operational efficiencies, better patient experiences and lower costs. McLaren Health Care, Grand Blanc, Mich., is experiencing positive benefits from a supply chain overhaul in its non-acute care clinics executed alongside supply chain experts at Cardinal Health. As healthcare provider organizations navigate tumultuous times, they can learn from McLaren’s initiative to standardize its supply chain for lasting effects.

Seeking a Standardized Approach

After a successful supply chain transformation in its acute care locations (13 hospitals at the time—the fully integrated, nonprofit system now includes 15 hospitals in Michigan and Ohio), McLaren Health Care wanted to take a similar approach in its 200 clinic locations throughout Michigan. The clinics are part of McLaren Medical Group, which employs nearly 500 physicians.

Each clinic had a unique supply chain setup, resulting in inconsistencies in areas such as product purchases and inventory stockouts, and purchasing decisions were based primarily on clinician preferences. In addition, the clinics

weren’t using the health system’s enterprise resource planning (ERP) software, with individual clinics instead functioning as standalone facilities and ordering supplies from local and internet suppliers using a mixture of payment methods. Further complicating matters, McLaren’s supply chain leadership had minimal visibility into clinic purchase orders, additions and changes, and the system lacked a well-defined process for communication between supply chain leadership and the clinics.

“The individual clinics were each responsible for their own world, and there just was not a good, standardized approach,” says David Bueby, corporate vice president, Supply Chain Management, McLaren Health Care.

To help fix these issues, in 2016, McLaren expanded its existing partnership with Cardinal Health and embarked on an initiative to build a more efficient, standardized supply chain.

Building a Better Supply Chain

In its plan to standardize the medical group clinics to McLaren’s already existing supply chain practices, the team set multiple goals, including:

- Unifying all clinic locations to cohesive system processes.
- Ensuring clinic spending aligns with established contracts and finance practices.
- Empowering staff to manage procurement for their individual locations.
- Continuing development of an integrated delivery network product formulary with a focus on clinic alignment.



- Supporting providers and practices with a standardized product experience across all locations.

A major part of the initiative was bringing all clinic locations on board with the health system's ERP system and establishing an enterprisewide product formulary. To help ease initial resistance from some of the clinics, which were being asked to make a substantial transition in their products and processes, Bueby and his team made face-to-face meetings at the clinics a priority.

"This was not done remotely or through email—it was a joint effort with Cardinal Health and my staff to go out physically to those clinics and speak with clinic leadership, physicians and the staff who are responsible for ordering product," Bueby says.

As the clinics transitioned to McLaren's ERP system, the supply chain team held weekly Q&A sessions and meetings with clinic leadership and staff members to identify and problem-solve workflow and ordering challenges. The team also provided clinic staff with educational reference materials and set up an informational hotline.

As a result of the supply chain transformation initiative, clinic staff now place and send orders via a series of internal approvals that the McLaren Health Care corporate team and Cardinal Health support. Supply chain leaders have access to data and insights previously unavailable, which helps them monitor and compare supply chain performance systemwide. Additionally, the standardization of clinic formularies has reduced the clinics' SKU count from more than 3,400 items to 1,979 items, with a more effective approval process in place for adding or removing items.

Key Lessons

Bueby says three key lessons stand out from his experience with this initiative. The first is the importance of having a clear goal. For McLaren, that meant approaching this project through the lens of what Bueby refers to as the "one McLaren" environment.

"That means the experience in a single clinic in the middle of Michigan is no different than that in a large hospital in an urban setting," he says. "If you start with that goal in mind, it can bring the success you're expecting such as reduced cost, improved processes, efficiency and patient satisfaction."

The second lesson is the importance of organizational commitment "from top to bottom," according to Bueby. "That includes committed staff, committed leadership and a committed supplier partner," he says.

Finally, having a competent collaborator that understands the organization is vital.

"You can have the best plans in the world, but if the partner that supports those goals falls short, the plan doesn't mean anything," Bueby says. "More than half the successes we have had are because of the significance of what Cardinal Health has brought to the table. It's important for health system leaders to look to your partners and evaluate your partners and make sure they are up to the task."

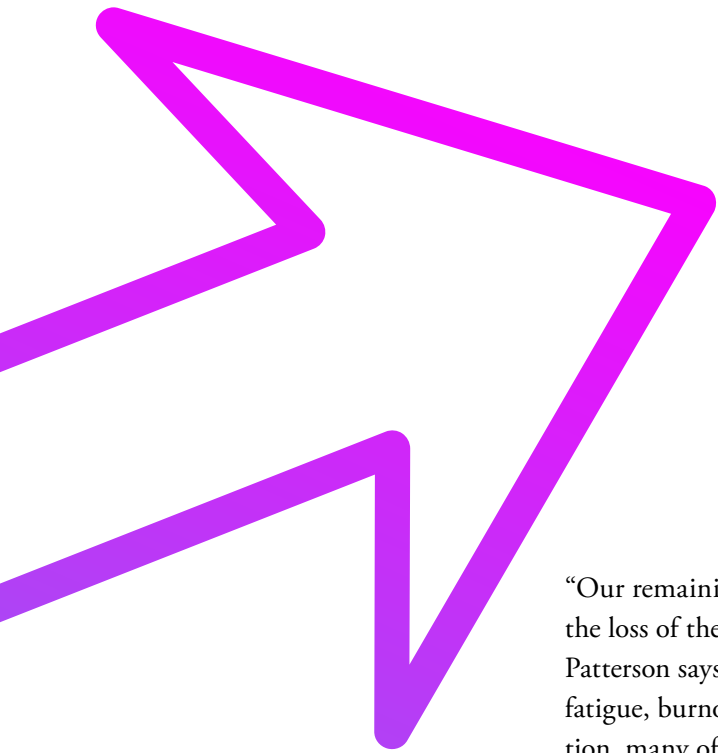
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OPTIMIZING OPERATIONS AND CAPACITY

Despite
Personnel Shortages

By
Maggie
Van Dyke



Across the country, hospitals continue to be challenged with personnel shortages brought on or worsened by COVID-19. At UAB Hospital, Birmingham, Ala., the highest vacancy rates are among nurses, respiratory therapists, patient care technicians, radiology staff and support services, such as food service, environmental services and patient transport.

CEO Anthony Patterson, FACHE, points to numerous persistent issues contributing to these labor gaps, including the retirement of baby boomer-age staff, the difficulty and distress of caring for COVID-19 patients, and the lure of high-travel agency salaries.

“Our remaining staff have really felt the loss of the people who left,” Patterson says. “Many are suffering fatigue, burnout and stress. In addition, many of our front-line leaders are stretched and feeling significant effects from trying to keep a large hospital functioning at optimum levels.”

Despite these challenges, hospitals have achieved what has seemed at times like an impossible goal: keeping operations as close to normal as possible.

“The fact that we were able to do that during COVID is impressive, given some of the shortages that we experienced,” Patterson says.

Paul Hinchey, MD, is also proud of the achievements and tenacity of hospital staff at University Hospitals, a 23-hospital system that serves Northeast Ohio. “Our people have been working really hard, like they are everywhere in healthcare,” says

Hinchey, president, UH Community Delivery Network, and an ACHE Member. “We’ve relied on them to come up with solutions to address labor and operational issues, and we’re proud of the job they’ve done.”

Hinchey, Patterson and other leaders share some of the strategies and solutions their hospitals and health systems have used to optimize operations during this most difficult time for healthcare.

Challenge Assumptions

A key to identifying solutions to personnel shortages is having an open mind. “Probably the biggest thing we’ve learned is to challenge our assumptions about how things work,” Hinchey says. “By asking a series of ‘why’ questions, we can uncover opportunities.”

For instance, University Hospitals was recently short on cardiac catheterization lab nurses, which was impacting the health system’s ability to perform those procedures. To solve the capacity problem, staff identified tasks that catheterization lab nurses typically perform, such as taking vital signs, that could actually be completed by medical assistants,



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paramedics and other available staff. As a result, the lab continued performing the same number of procedures with fewer nurses.

At UAB Hospital, leaders examined the roles registered nurses filled and converted several to positions that licensed practical nurses now occupy. The hospital also created a student nursing aide position and hired more than 70 students who have completed their basic nursing courses to fill that role.

“We worked with our Alabama Board of Nursing to define the role of these student nursing aides,” Patterson says. “They are not quite patient care techs and not quite LPNs. But, because they are in nursing school, they have a knowledge base that makes them useful team members at a rapid pace.”

Rethink Where Patients Go

At Community Memorial Health System, leaders redesigned the organization’s delivery approach to optimize operations during COVID-19 surges. The Southern California system consists of two hospitals: Community Memorial Hospital, a 250-bed facility in Ventura, and Ojai Valley Community Hospital, which includes a 25-bed critical access hospital and a 66-bed skilled nursing facility in the small town of Ojai.

“Our two hospitals worked together and pooled our resources to best serve our community,” says Haady Lashkari, FACHE, chief administrative officer, Ojai Valley Community Hospital, and vice president, Community Memorial Health System.

larger hospital, which is about 30 minutes away.

The health system then used the existing skilled nursing beds at Ojai Valley, as well as swing beds in the critical access hospital. After being discharged from Community Memorial, COVID patients were transferred to Ojai Valley to recover. This helped ensure that patients could get skilled nursing care at a time when communities around the country had a severe shortage of those beds.

At UAB Hospital, leaders recognized the need to increase capacity for essential and complex surgical cases. So the tertiary academic medical center transferred noncomplex ambulatory surgeries to affiliate hospitals across the state.

“Probably the biggest thing we’ve learned is to challenge our assumptions about how things work. By asking a series of ‘why’ questions, we can uncover opportunities.”

Paul Hinchey, MD
University Hospitals

The student nursing aides are helping with staffing shortages. “If we only have four of the five nurses needed on a unit, but we’ve got two nursing student aides who are eager to help, it improves the burden on the nurses,” Patterson says.

At the start of the pandemic, leaders established a COVID-19 unit at Community Memorial Hospital, which was better equipped to care for a high number of very sick patients. COVID patients from Ojai Valley were transferred by ambulance to the

“We’ve moved about 8,000 lower-acuity cases to these other sites since 2019,” Patterson says. “Now our staff and recovery rooms are not taken up with cases that can be accomplished in a lower-acuity environment. The university hospital has become a more inpatient-centric hospital.”

UAB Hospital also distinguishes between surgical patients scheduled for less-intensive and more-intensive procedures in order to augment inpatient bed capacity. In the past, all surgical patients stayed on a medical-surgical unit after their operations. Now the hospital places patients with less intensive procedures in the hospital’s pre-operative and post-operative



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Despite Personnel Shortages

units until they can be discharged. An example of this might be a patient admitted overnight for a cardiac catheterization. This also allows for more timely bed placement for complex high-acuity cases.

“This has helped us to stay open for the kind of essential surgical volume that would be unique to UAB such as transplant, stroke care or trauma volumes,” Patterson says.

Address Staffing and Patient Flow Issues

Since it was established about 10 years ago, UAB Hospital’s Center for Patient Flow has helped ensure that patients get discharged or transferred in a timely fashion and that beds are available for incoming patients. The center is staffed by nurses who oversee bed management. Care management, environmental services and other functions regularly interact with the center.

When COVID-19 hit, the center’s role became even more important.

“It was an all-hands-on-deck team effort, but that group was pivotal to keeping patients flowing and keeping up with where all the patients were,” Patterson says.

Marty Sargeant, CEO, Keck Medicine of USC, credits a tiered huddle process with helping the Los Angeles-based academic medical center to manage capacity. Every morning, brief safety huddles are held at staggered times at different levels of the organization to identify problems and concerns. The process begins with meetings on individual nursing units and ends with a meeting of senior executives. Issues that cannot be addressed by front-line staff are escalated up the leadership command.

“Through that tiered huddle process, as well as the technology we use to help with hospital throughput, we can anticipate the demand for resources and compare those demands with trends like employee call-offs,” Sargeant says. “It helps us

figure out, for example, how to manage some of the less acute volumes so that we are always available for more acute care episodes.”

Determining how many and what type of staff are needed is a key to ensuring adequate patient flow and capacity. But the traditional way of determining staffing needs, which relies heavily on historical census data, did not work well during the pandemic. “When COVID hit, history became the enemy of the forecast,” says Bryan Dickerson, vice president of workforce, Hospital IQ, an AI-based operations management platform.

To better predict staffing needs during a public health emergency like COVID-19, forecasts need to consider more real-time data such as local COVID-19 trends and acuity levels of patients being seen in the ED, Dickerson says.

Pursue Process Automation

In 2019, University Hospitals created a Process Automation Center. Considered a type of artificial intelligence, process automation entails programming a computer to take over mundane, repetitious tasks.

The center has focused mostly on revenue cycle and finance functions since it launched, reducing the number of staff needed to perform certain back-office tasks such as claims management. “They are focused on automating manual processes and

“If we only have four of the five nurses needed on a unit, but we’ve got two nursing student aides who are eager to help, it improves the burden on the nurses.”

Anthony Patterson, FACHE
UAB Hospital

then managing by exception so they only need to chase the outliers,” Hinchey says.

During the pandemic, the Process Automation Center also reduced the documentation burden on nurses, freeing up nursing time by about five full-time equivalents. The process automation solution works in the background 24/7 to process orders that nurses used to have to handle manually. Nurses would have to address 500 to 600 transactions on their computers; now they have 20.

Keck Medicine has also been experimenting with using process automation to assist with back office functions. Looking to the future, the hospital hopes to use artificial intelligence to help reduce the documentation burden on clinicians. “If you ask clinicians, documentation is at the top of the list in terms of what they don’t want to do,” Sargeant says.

Deploy Remote and Virtual Care

University Hospitals has also invested in remote patient monitoring technologies, which is helping with patient flow and capacity issues. The system can now send patients home in a more timely manner with wearable devices, which allows a team of hospital nurses to keep tabs on the their pulse rates, blood oxygen levels and other health indicators.

“Centralized remote patient monitoring really facilitated our ability to better utilize our home-care services

to manage volume when that demand was just off the scale,” Hinchey says.

The hospital also launched a service called Hospital@Home in March 2021 to increase hospital capacity and continue to care for patients who need intermittent observation but not round-the-clock care. The service essentially brings hospital services to the patient using a combination of telemedicine, remote monitoring and in-home or virtual visits by care team members, including physicians, nurses, pharmacists and physical therapists. In addition, a paramedic from the health system’s EMS Institute visits every day.

“Hospital@Home is a huge patient satisfier, and it’s helpful for throughput,” Hinchey says. “It’s a win-win all-round.”

Other hospitals are also reporting multiple benefits from deploying various types of virtual approaches to care. For instance, Community Memorial Health System

“Through that tiered huddle process ... we can anticipate the demand for resources and compare those demands with trends like employee call-offs. It helps us figure out ... how to manage some of the less acute volumes so that we are always available for more acute care episodes.”

Marty Sargeant
Keck Medicine of USC

implemented a tele-sitter program that has reduced the number of patient sitters needed. “Patient sitters are a difficult position to fill,” Lashkari says. “After putting 360-degree cameras in our patient rooms, one tele-sitter can now monitor 12 patients at a time.”

The system provides two-way communication so the tele-sitter can coach patients about fall prevention or alert unit staff to any safety issues in patient rooms. In addition to easing staffing issues, the tele-sitter program has reduced falls by 50 percent at Community Memorial Hospital.

Boost Recruitment and Retention

Labor is tight across the country, which is driving up wages in many markets and making hiring that much more difficult for the health-care field, according to Hospital IQ’s Dickerson.

For example, for UAB Hospital, a new employer in town has increased the area wage rate for entry-level

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jobs, such as food service, patient transport and other support services. Amazon opened numerous warehouses and fulfillment centers in Birmingham, Ala., creating thousands of well-paid entry-level jobs.

To compete, UAB Hospital raised wages for support staff and other front-line employees. The hospital is also looking into issuing paychecks in a more timely fashion, such as after every shift versus every two weeks.

finish their internships, many students want to continue on their careers with us.”

One way Keck Medicine is competing for—and retaining—staff is by emphasizing the potential for growth and development within their organizations. Sargeant points to several employee success stories there, including one who started as a central sterile processing technician and is now an RN in the post-anesthesia care unit.

flexibility and respect. They want a sense of purpose.”

By building a culture that addresses these employee desires, hospitals will naturally address many recruitment and retention challenges, Sargeant says. “If we don’t have a culture that engages staff and gives them a sense of purpose, we’re going to be chasing compensation and turnover. And that’s not where we need to spend our time. My focus is on building a culture of purpose that values human beings.”

“Patient sitters are a difficult position to fill. After putting 360-degree cameras in our patient rooms, one tele-sitter can now monitor 12 patients at a time.”

Haady Lashkari, FACHE

Ojai Valley Community Hospital and Community Memorial Health System

Community Memorial Health System is betting on its “grow-our-own” strategy to help keep itself staffed into the future. The health system developed a physician residency program, and currently has 88 residents across five specialties. In addition, it offers residencies and internships for newly graduated nurses, clinical lab scientists and registered dietitians.

“It gives them an insider view of our health system and our culture,” Lashkari says. “By the time they

“When someone starts at our hospital, we tell them what their possible career pathways are and then pull all the levers for them,” Sargeant says.

Prioritize Culture

Amid the challenging personnel shortages that hospitals are facing, Sargeant sees an opportunity he calls “The Great Realization.” “The pandemic has heightened our employees’ desires for something bigger and better,” he says. “They want worthwhile work. They want

Engaging front-line leaders in culture work is critical, leaders stress. To that end, UAB Hospital is implementing an accountable care team framework across its nursing units. Units are led by a triad of managers: a physician, a nurse and an operational leader. The managers engage all unit staff in weekly process improvement meetings that focus on improving patient outcomes, discharge efficiency and other aspects of care and operations.

In employee surveys, staff on units that have adopted accountable care teams report greater feelings of autonomy, resilience, community and teamwork.

The framework is a type of “psychological PPE,” Patterson says. “It helps to convey a sense of teamwork and that you are all in it together.”

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

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Paul B. Hofmann, DrPH,
LFACHE

Promoting the Joy of Mentoring

Proper mentoring can be mutually rewarding and enjoyable.

Although the value of mentoring should be self-evident, it is also clear that healthcare executives have a moral obligation to mentor the next generation of leaders. Doing so benefits both our successors and the organizations we serve.

In 2001, in response to the impressive inquiries being posed by Jeff Noblin, a young executive matched with me through ACHE's Leadership Mentoring Network, I asked if he would join me in co-authoring an article for *Healthcare Executive*, which would include my

answers to his questions (see sidebar on this page for a list of some of these insightful questions). In that article ("Mentoring Dialogue: Critical Questions and Answers," November/December 2002), we wrote that mentoring benefits mentees in three ways:

- The person has convenient access to a senior executive who has an interest in his or her career, and the relationship's objectives and expectations are jointly determined.
- Learning the intricacies of management through observations and analysis, followed by timely discussions, helps the junior executive become more sophisticated in addressing organizational issues.
- A young manager might feel hesitant to ask certain questions of a colleague or direct supervisor, but the mentee should feel less inhibited in raising issues with a mentor.

In retrospect, Noblin and other mentees would probably agree there are additional advantages to having an effective mentor. These include refining their professional values; developing stronger communication and leadership skills; honing other skills and expertise they need to succeed; establishing short- and long-term career goals; improving job satisfaction, performance and self-confidence; being exposed to new and different perspectives; expanding their professional network; being better prepared for interview questions; and identifying and addressing possible gaps in skills and

Questions Mentees Should Ask

The following questions appeared in the article "Mentoring Dialogue: Critical Questions and Answers" in the November/December 2002 issue of *Healthcare Executive*. They remain relevant questions for mentees to ask their mentors today:

- What specific skills should I be developing at this point in my career?
- If you were recruited to another institution, how would you evaluate the organization?
- What are the best steps to determine how a competing facility or health system is doing financially and operationally?
- Given the number of opportunities available in rural areas, what are the pros and cons of working in these settings?
- How will the role and influence of physicians be changing in the future?
- How should leadership respond when union organizing is initiated?
- If one or more individual board members begin to intercede by crossing the sometimes-ambiguous boundaries between governance and management, what should be done?
- Will physician influence in the healthcare setting become more prominent or diminish in the future?

knowledge. Of course, a good mentor will also share one of life's most critical lessons—the need to maintain a healthy work-life balance.

At the time the 2002 article was written, Noblin was a project manager at a health system in Albany, Ga. Not surprisingly, given his perceptive questions, he is now board certified in healthcare management as an ACHE Fellow and the CEO of Pleasant Valley Hospital in Point Pleasant, W.Va.

Benefits of Being a Mentor

It is unlikely that any effective executives have succeeded without having multiple mentors during their careers. Administrative residents and fellows are tutored by preceptors. Junior managers are mentored either formally or informally by their supervisors. Once becoming a senior executive, one should feel an innate instinct to reciprocate. It is rewarding—often in intangible ways.

Being a mentor is immensely satisfying and fulfilling. Based on my experience, early careerists who apply to ACHE's mentoring program (the Leadership Mentoring Network) or the National Center for Healthcare Leadership's Mentorship Program are unfailingly highly motivated and conscientious. Healthcare executives should also be strategic about how they approach mentoring and identify the programs that best fit their individual needs. The National Association of Health Service Executives and the National Association of Latino Executives have robust mentoring programs, as do many ACHE chapters. Every mentee has different

strengths and needs, making each interaction with a mentor, whether by email, phone, an online video platform or in person, stimulating and thought provoking. Being a mentor also helps one become a better listener.

It is unlikely that any effective executives have succeeded without having multiple mentors during their careers.

Yes, all senior executives have full schedules. But the time required is nominal, and the good feeling derived from contributing to the profession is immeasurable.

Both ACHE and NCHL ask mentors and mentees to complete a brief questionnaire soliciting feedback on the experience. However, mentors should frequently request informal confirmation from mentees that the experience is meeting their needs.

Mentees are encouraged to determine the interval between conversations. Typically, mentees and mentors meet monthly for an hour with the understanding that emails raising questions or giving updates are appropriate at any time. Though the duration of the relationship is usually six to 12 months, I always inform mentees that they can and should decide when it will conclude. Some associations have lasted for more than a year.

Fundamental to any relationship is mutual trust, thus building a strong

foundation for this trust should be a high priority. For example, the mentee must feel conversations will be kept confidential by the mentor, especially if the mentor is employed by the same organization.

Never Too Late to Consider Mentoring

Ideally, organizations that promote the joy of mentoring will benefit because eventually they will become more recognized as having nurturing cultures and enjoying higher rates of employee engagement and retention. In a June 8, 2021, *Harvard Business Review* article titled "You Need a Skills-Based Approach to Hiring and Developing Talent," LinkedIn CEO Ryan Roslansky noted a LinkedIn 2018 Workplace Learning Report that indicated 94% of employees admitted they would have stayed at a company longer if it had invested in their career.

Having a meaningful and ethical professional career is crucial for countless reasons, including ethical ones, so it is never too late to be reminded of Winston Churchill's astute observation: "We make a living by what we get. We make a life by what we give."▲

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

Editor's note: Find out more about ACHE's Leadership Mentoring Network at ache.org/Mentoring.



Eugene A. Woods,
FACHE

A Pearl for the Community

Atrium creates innovation and research district with inclusivity, jobs in mind.

When Atrium Health began its strategic combination in 2019 with Wake Forest Baptist Health (now known as Atrium Health Wake Forest Baptist), headquartered in Winston-Salem, N.C., a new vision for the future of healthcare, medical education, innovation and research in the region was born. With an influx of fresh ideas and inspiration as the shared values of the respective organizations aligned, we immediately began to envision the future: to bring together our hospital systems, to build a second campus of Wake Forest University School of Medicine in Charlotte, N.C., and to expand on the entrepreneurial spirit of both organizations by developing an innovation district in Charlotte that would link to Winston-Salem's "Innovation Quarter."

We look forward to our collective future ... where we explore and champion new, innovative ways to improve health, elevate hope and advance healing—for all.

The focus from the beginning has been to plant the seeds for transformational impact through health,

learning and community, and our vision strives to reflect just that. Today, our combination with Atrium Health Wake Forest Baptist is well underway, and progress with Charlotte's innovation district continues to gain momentum.

Honoring the Past, Looking to the Future

The district will be constructed in an area of Charlotte formerly known as Brooklyn, which, for years, was a thriving African American community of families, businesses and faith-based institutions. Urban renewal displaced most of the neighborhood in the 1950s, with Pearl Street Park standing as one of few remaining landmarks.

Recently named "The Pearl," the innovation district both acknowledges the area's past and looks toward its future as a place shaped by diverse people and perspectives and rooted in inclusivity and belonging. This mixed-use community, centered in academics and research, will feature office, retail, housing and hospitality spaces. It will have an open-door policy, where people from all walks of life are welcome to enjoy free coworking space, participate in community yoga or enjoy a history exhibit.

Put simply, The Pearl will be a place where Charlotte's historic vitality meets its innovative future.

Serving as ground zero for entrepreneurship and innovation, The Pearl will attract clinicians, scientists, investors and visionaries from around the world to collaborate on breakthrough technologies and cures, providing life-changing care for all in rural and urban communities alike. To further promote Atrium Health's vision of a space that is home to all, the organization has set aside funds to invest in minority-owned startups in the life sciences industry.

Additionally, The Pearl will house over 3,500 learners each year, across more than 100 specialized programs, including Wake Forest University School of Medicine Charlotte. This will help reduce the shortage of doctors, nurses and allied health professionals in underserved communities.

Creating Jobs and Promoting Inclusivity

Through The Pearl, we also are determined to create jobs that provide inclusive opportunities and enhance the economic vigor of the entire region. As we begin preparing for the groundbreaking of The Pearl later this year, we're intentionally creating opportunities for small, minority-owned businesses to participate in the construction and maintenance of the district itself. And during the next 15 years, The Pearl and its tenants are projected to create more than 5,500 on-site jobs—30% to 40% of which are not expected to require a college degree—and more than 11,500 jobs, in total, in the Charlotte community.

This job growth will deepen the community's need for a robust pipeline of STEM talent, so we also are investing to ensure that today's learners are exposed to the many types of jobs that the district will create. As an example, we hope to build a STEM Experiential Learning Lab on campus so students from local middle and high schools can learn alongside The Pearl's researchers, scientists, doctors, nurses, engineers and allied health professionals. We are also investing in collegiate scholarships and internships to support Black students pursuing healthcare careers through programs like our Bishop George E. Battle Jr. Scholarship and partnership with Johnson C. Smith University.

We are also working to build new partnerships that will bolster the impact of The Pearl across our

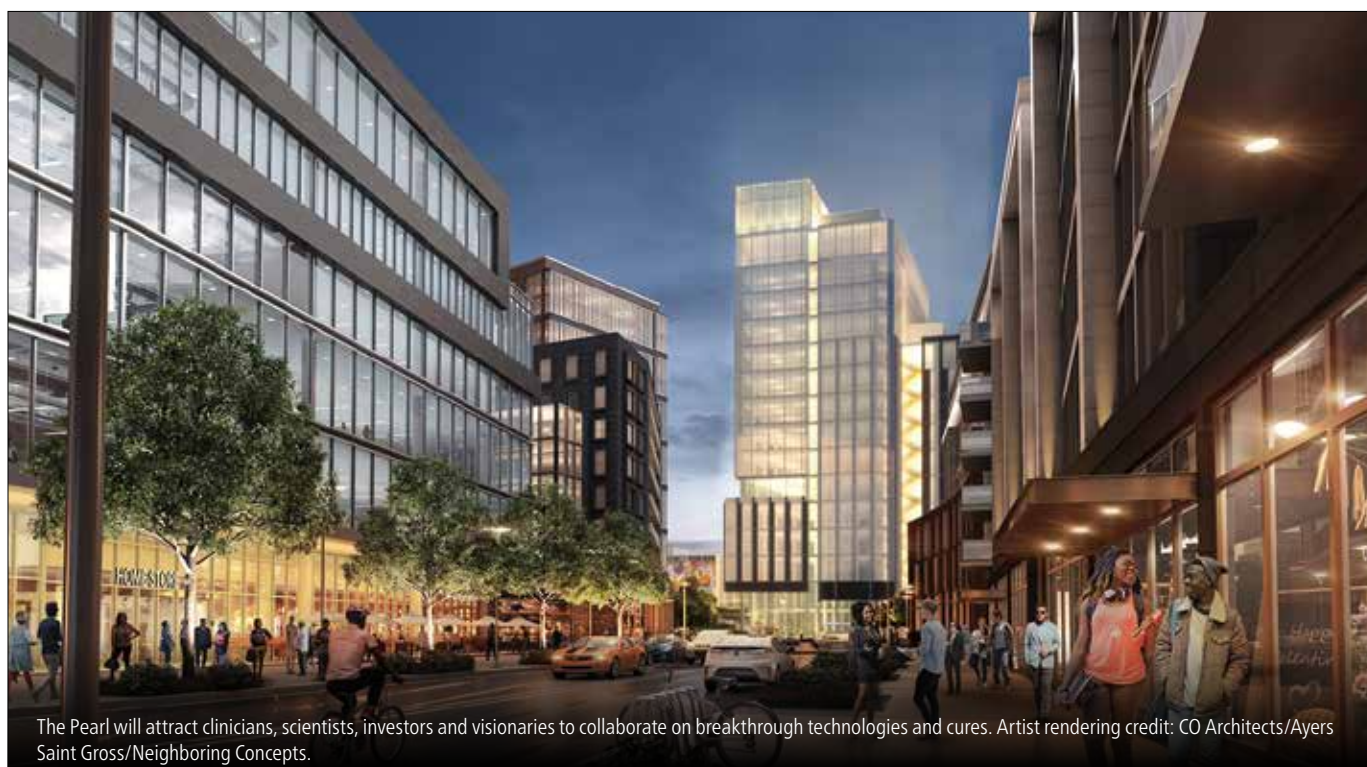
region. For example, earlier this year, IRCAD, the French-based research and training institute for the world's finest surgeons, announced its intent to establish its North American headquarters in Charlotte, at The Pearl. When fully operational, IRCAD North America will be a "super magnet," attracting new businesses, innovators and surgeons every year to train and collaborate on the latest surgical techniques. Like every tenant who joins The Pearl, IRCAD's partner organizations will also make commitments to social impact, further supporting the aspirations that we have set forth for the district.

While many steps remain in our 1,000-step journey toward bringing this monumental opportunity to life, our vision has remained clear at every turn along the way thus far. Mahatma Gandhi once said,

"The future depends on what we do in the present." And while Atrium Health will forever remember and honor the roots of its communities, it is in the same spirit of Gandhi that we work relentlessly *today* to fulfill our vision for *tomorrow*.

Together, with our partners around the globe, we look forward to our collective future—a future where we usher in the next era of health-care, education and research for our region; where we give back to our communities through economic opportunity and advancement; and where we explore and champion new, innovative ways to improve health, elevate hope and advance healing—for all. ▲

Eugene A. Woods, FACHE, is president/CEO of Atrium Health, Charlotte, N.C. (chiefexecutiveofficer@atriumhealth.org).



The Pearl will attract clinicians, scientists, investors and visionaries to collaborate on breakthrough technologies and cures. Artist rendering credit: CO Architects/Ayers Saint Gross/Neighboring Concepts.



Scott Kashman, FACHE



Lorissa MacAllister, PhD,
AIA, NCARB



Michael J. Markel Jr.,
RN, FACHE

Designed to Care

Creating an environment that supports a culture of wellness and caring.

Staff shortages are a top concern for healthcare executives today, as many health systems are being pushed to review staffing ratios, shorten orientation and onboarding time, and increase overtime within an already exhausted system. With gaping holes in the workforce, the remaining staff steps in to fulfill the requirements, further straining the physical health and psychological wellness of the workforce.

The pandemic has shone a light on fractured systems and on looking at the workforce differently—and the time is now to create environments of care that support and enhance collaboration.

Research has demonstrated, especially in healthcare, that when a healthy workforce is the focus, outcomes improve. Conversely, when our workforce is shrinking and exhausted, outcomes suffer, and quality and safety, engagement, turnover, patient experience, and lengths of stay all are negatively affected.

A key solution to these challenges is a supportive organizational culture and building designs created around caring for the caregivers, which will enable them to work at the top of their licenses. It is time to turn

additional energy toward reengaging staff and keeping them well. Creating a workplace environment that promotes health integration, respite and empathy takes a focused strategy, clear planning and a systematic approach. Following is advice for getting started.

The time is now to create environments of care that support and enhance collaboration.

An Optimized Workplace Environment

Optimizing the workplace environment and physical spaces for staff makes it easier for people to do their work and stay healthy and resilient. In addition, tailoring a staffing model for the organization that supports a future team-based wellness culture is another key to creating a supportive workplace environment. Leaders also should look at restructuring staffing models and improving programs to retain staff.

Change the workplace layout.

The environment plays a pivotal role that can be retooled and used to ensure the highest outcomes

for patients and staff, according to the article “Staff shortages: Environmental and organizational determinants and implications for patient satisfaction,” published April 2020 in *Health Policy*. Proven physical environment plans that support and improve staff retention, engagement, recruitment and overall organizational performance include:

- Creating a team collaboration work area that allows for direct visualization to patient care areas and a dedicated space for staff to work together across disciplines.
- Developing a wellness team task force to guide and prioritize the organization’s efforts.
- Providing healthy meal options for staff and discounts for healthy choices (for example, fruit, vegetables, water, salads and baked hot entrees).

This column is made possible in part by Cerner Corporation.



Official Notice for the 2022–2023 Council of Regents Elections



American College of
Healthcare Executives
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This official notice serves as the beginning of the election process to select new Regents to serve on the American College of Healthcare Executives' Council of Regents, the legislative body that represents ACHE's more than 48,000 members. Service as an elected official is a unique opportunity to exercise your leadership ability, share innovative ideas and act on behalf of fellow members.

All Fellows who wish to run for election must submit an electronic letter of intent to elections@ache.org by Aug. 26, 2022. If you submit your letter of intent and you haven't received confirmation by Sept. 2, 2022, contact Caitlin E. Stine at (312) 424-9324 or cstine@ache.org.

Please note:

- New Regents will each serve a three-year term on the Council of Regents, beginning at the close of the March 2023 Council of Regents meeting during ACHE's Congress on Healthcare Leadership.
- Members are assigned to a Regent jurisdiction based on their business address.
- This official notice is the only notification for the 2022–2023 Council of Regents elections.

If you would like additional information about the responsibilities of a Regent and what to include in your letter of intent, please contact Caitlin E. Stine at (312) 424-9324 or cstine@ache.org.



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Michigan & Northwest Ohio
Minnesota

Mississippi
Missouri
Montana
Navy
Nebraska & Western Iowa
Nevada
New Jersey—Northern
New Mexico & Southwest Texas
New York—Northern and Western
North Carolina
North Dakota
Ohio

Pennsylvania
Pennsylvania—Southeast &
Southern New Jersey
Puerto Rico
Rhode Island
South Carolina
Tennessee
Texas—Southeast
Vermont
Virginia—Central
Washington
Wyoming

- Rethinking staff break areas for active (room to stretch or share conversations) and passive (quiet area to read a book or listen to music) activities.

Staff cannot work in isolation, and with the continued reduction in workforce, changing the layout of the environment can improve care outcomes and reduce staffing requirements. Research has shown that a highly connected space can allow for improved outcomes, including an increase in patient safety.

At Henry Ford Macomb Hospital in Clinton Township, Mich., moving from several units with various total bed counts to the standard 40 beds per floor or 20 beds per zone supports efficient nurse-to-patient ratios of 1-to-4 or 1-to-5. New bed counts also create improved standardization for staffing on all units.

Tailor a staffing model to support a future team-based wellness culture.

St. Dominic Hospital in Jackson, Miss., is piloting a collaborative care model using registered nurses, licensed practical nurses, certified nursing assistants and medical assistants. The goals of the redesigned staff model include:

- Transforming the nursing care model to meet ongoing RN shortages.
- Redefining how bedside patient care is provided.
- Improving effective communication across all disciplines.

A Culture of Caring

The nursing department at Henry Ford Macomb Hospital has focused on a culture-of-caring model for several years. The activities are

centered around the nursing care model within Jean Watson, RN, PhD's Theory of Human Caring (watsoncaringscience.org).

The plans for a new inpatient tower design, including the remodeling of current rooms and all community spaces, were designed with "caritas processes" in mind (examples of these processes include developing trusting, interpersonal and caring relationships; engaging in genuine teaching-learning experiences; and creating a caring-healing environment for all involved).

During planning of the project, which was completed in 2020, representatives from executive leadership and the architectural/design teams created objectives to increase efficiency, improve care experience, promote quality and safety, inspire people, maintain recognition as the premiere health system in the market and decrease costs. All objectives are intended to impact human caring.

Additionally, the team partnered with a Detroit-based artist to promote caring and healing for team members, patients and families. Initially, the artist led a group of nursing leaders in planning for and creating a work of art. Nursing leaders submitted individual pieces of pixel art that were crafted into a lotus flower (see photo to the left).

The strategy with the pixel art technique was to bring together diverse communities in the production of a large-scale work of art. The lotus was chosen to depict the resilience of the



healthcare team, patients and families. The artwork now hangs in the hallway of a medical/surgical/oncology unit.

The technological support team, inspired by the new inpatient tower design, incorporated design features that allow for the possibility to operate all rooms at any care level. Features include nursing stations located adjacent to patient rooms, in-room documentation computers, contemporary nurse call systems with transaction/data tracking, ceiling-mounted cameras with two-way audio for remote call monitoring, and e-care functions that can deliver improved patient experience through web-based tools. These technologies help ensure patients and staff are supported at all levels of care.

As health systems continue to be strained by the demands of staffing issues, considering the effectiveness of the environment that surrounds staff is vital. A curated environment that supports teamwork, reflects the organization's culture and provides access to support allows each staff member to be fully present and able to work at their best. ▲

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Paul H. Keckley, PhD

The CMS Innovation Center: 12 Years Later

What role does CMMI play in today's healthcare environment?

The CMS Innovation Center, also known as CMMI, was established by Congress in 2010 as part of the Affordable Care Act. Created to identify ways to improve healthcare quality and reduce costs in Medicare, Medicaid and the Children's Health Insurance Program, its statutory focus was to develop and test new healthcare payment and service delivery models, such as alternative payment models, to improve patient care, lower costs and better align payment systems to promote patient-centered practices.

In 2021, the CMS Innovation Center underwent a "strategy refresh" led by

Deputy Administrator and Director of CMMI Elizabeth Fowler, PhD, JD. Built on lessons learned from its first decade in existence (see sidebar below) and over 50 models launched, the new strategy was created with a vision "for a health system that achieves equitable outcomes through high quality, affordable person-centered care."

The objectives of the new strategy are clear, funding for CMMI is secure, and overall, the CMS Innovation Center's new post-pandemic approach to value-based purchasing is sensitive to improvements needed in the structure

of its value-based programs and responsive to provider hesitance to participate. What isn't evident is the role that CMMI will play in transforming a field that's simultaneously navigating pandemic-induced workforce shortages, upticks in medical debt, an uncertain value-based care agenda and declining public confidence.

The 2021 Strategy Refresh

Funding for CMMI, established under the ACA, is not subject to annual appropriations that can become mired in partisan bickering. However, the six directors who have led CMMI in its 12-year history have nonetheless steered the center toward executive branch goals. The Biden administration is no exception: The focus for CMMI's efforts under the new strategy reflect the White House's priorities for the Centers for Medicare & Medicaid Services.

Fowler, who is leading CMMI's updated strategic objectives, is an experienced Capitol Hill health policy expert, having worked in key roles in the Obama administration after stints at the Commonwealth Fund, Johnson & Johnson and Wellpoint Inc., now Anthem. She has organized CMMI's programs into eight buckets: prevention and population health, patient care models, seamless care models, a state innovations group, a research and rapid cycle evaluation group, a policy and programs group, a learning and diffusion group, and a business services group.

She has also initiated a top-to-bottom review of each alternative payment model and program under CMMI's oversight and issued the strategy refresh March 16, 2022, to alert industry stakeholders and

Lessons Learned From CMMI's First 10 Years

Established in 2010, CMMI developed and tested more than 50 models, which the center says have "yielded important policy and operational learnings that provide a foundation for the strategy refresh." Following are a list of lessons learned during CMMI's first decade:

1. Ensure health equity is embedded in every model.
2. Streamline the model portfolio and reduce complexity and overlap to help scale what works.
3. Tools to support transformation in care delivery can assist providers in assuming financial risk.
4. Design of models may not consistently ensure broad provider participation.
5. Complexity of financial benchmarks have undermined model effectiveness.

polymakers to the center's new priorities during her term as its leader. Following are five strategic objectives that will guide CMMI's implementation of its new vision.

The CMS Innovation Center's new post-pandemic approach to value-based purchasing is sensitive to improvements needed in the structure of its value-based programs and responsive to provider hesitance to participate.

Drive Accountable Care: Increase the number of beneficiaries in a care relationship with accountability for quality and total cost of care.

Advance Health Equity: Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Support Care Innovations: Leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives and payment flexibilities.

Improve Access by Addressing Affordability: Pursue strategies to address healthcare prices, affordability, and unnecessary or duplicative care.

Partner to Achieve System Transformation: Align priorities and policies across CMS and aggressively engage payers, purchasers, states and beneficiaries to improve quality, achieve equitable outcomes and reduce healthcare costs.

A Unique Application of Common Themes

The themes reflected in these strategic objectives are often discussed in healthcare circles and among lawmakers. However, their manifestation in how the Fowler-led CMMI will apply them is unique, as demonstrated by the following three examples.

There will be heightened attention given to equity in the design and implementation of all programs.

CMMI will specify how equity is to be measured for participation in its programs, taking into consideration how underrepresented perspectives are embedded in governance, leadership, patient benefits and provider performance measurement, and how care management is adjudicated to account for the unique clinical and social needs of diverse populations.

There will be increased attention given to provider participation in programs that show the most promise in improving value, i.e., lower costs and better outcomes.

CMMI will make certain programs mandatory and limit the role of business partners, such as private investors, consultants, etc. Additionally, the center will specify the rights and rules for participation based on input from a wide range of clinical decision-makers, including physicians, advanced practice nurses, pharmacists, nutritionists, etc.

There will be a focus on reducing Medicare spending by calibrating shared savings and bonus programs in various APMs with total costs of care that are verifiable, geographically discreet and accessible for comparisons. CMMI will aggressively monitor and litigate gaming of enrollment, risk scoring and coding

to optimize shared savings. Additionally, the center will add methodologies to APMs for measuring affordability and shared savings linked to affordable care improvements. It will also structure shared savings models sensitive to cost categories to be included in total cost of care calculations and aggregated total cost of care.

CMMI's Relevance Today

CMMI has been in the spotlight for 12 years, usually because of announcements for new value-based programs and rule changes for existing programs. Most of its pilots had limited success; only six out of the more than 50 models launched during its first 10 years generated statistically significant savings to Medicare and taxpayers, including bundled payment and accountable care organization models. Four of these programs met the requirements to be expanded in duration and scope, according to a CMS white paper on CMMI's strategy. However, their collective impact on health spending has been negligible: Spending is forecast to increase 4.6% annually through 2030—higher than annual increases in the gross domestic product and household wages. As Medicare faces budget shortfalls in its Part A program starting in 2026, CMMI programs will have done little to help.

The premise for CMMI—develop and test new ways of doing things—is solid. However, the reality is that in most healthcare organizations, risk avoidance and revenue protection are stronger motivations than participating in CMMI's programs. ▲

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Five Financial Benefits of Rehabilitation Partnership

As financial strain continues to impact hospitals across the country, health leaders are seeking partnership to increase financial stability amid an ever-changing healthcare landscape. Partnership can help hospitals effectively obtain additional resources to provide high-quality patient care, strengthen service lines, and improve access and the overall patient experience.

Read this article to discover how hospital leaders can overcome today's unique challenges and make the most of the growing opportunity through joint-venture or contract management rehabilitation partnership – ultimately benefitting your hospital's financial performance.

Proactively identifying efficiency opportunities and growth in services that will treat the needs of patients brought on by or exacerbated by the pandemic, while also bolstering the hospital's bottom line, is key to hospital success. Partnering with an experienced post-acute provider benefits the care continuum and can have substantial influence on hospital outcomes.¹

5 Benefits of Rehabilitation Partnership for Overall Hospital Success

With the help of an experienced partner, hospitals can enhance their post-acute strategies in five key ways:

1. Improved Performance Under Value-Based Care

The shift to value-based care has pushed hospitals to reduce spending while improving quality and outcomes. In a study of value-based trends, it was found that more than a third of national reimbursement contracts are now value-based. This percentage has trended upward every year since 2015.¹

A post-acute partnership strategy helps equip hospital staff and leadership with the resources to increase care quality and efficiency, make more timely transfers to post-acute settings, reduce readmission risk and generate long-term cost savings for the entire hospital.

2. Increased Care Efficiency to Reduce Readmissions

Re-hospitalizations and other transfers in the post-acute continuum can lead to poor patient satisfaction and care quality, ultimately creating negative financial consequences. Research shows that some of the lowest-performing hospitals around the nation can experience readmission penalties two to three times higher than those performing at an average rate.²

Through specialized expertise, access to national resources and data, and a team with a focused ability to recruit and retain top talent, a rehabilitation partner can greatly expand a hospital's ability to provide excellent patient care in an efficient manner. Further, a rehabilitation partner can help produce faster recovery times, reduced care costs and can create a more positive overall patient experience.

3. Increased Support of Medicare's "Triple Aim"

Successfully managing all aspects of a rehabilitation unit has become more challenging due to the growing complexity of patients treated, readmission risks and the expansion of value-based care integration. However, if a health system is able to achieve an effective post-acute strategy they can better manage the intricacies of the program.

Rehabilitation partnership supports Medicare's triple aim, helping to:

- **Enhance care.** Provide exceptional care to individuals

through high-quality programs aimed at improving a patient's health and independence.

- **Improve community health.** Experienced partners have access to the latest national trends and resources beyond the data available to individual facilities. This allows local programs to be equipped with best-in-class treatment plans to effectively treat a wider variety of complex conditions.
- **Lower care cost.** Greater patient access, expertise and quality lead to better outcomes, lower length of stay and lower readmissions. Additionally, facilities are able to more effectively deploy resources and improve operational efficiency, further lowering costs.

An effective partner will also have a well-organized system for efficiently transitioning patients through phases of care. This helps lower per-patient costs, improves regulatory compliance and enables patients requiring specialized care to receive high-quality treatment.

4. Specialized Care for COVID-19 and Medically Complex Patients

Throughout the pandemic, specialty hospitals have played an invaluable role in the public health response. Research notes that 20 percent of patients recovering from COVID-19 require facility-based rehabilitation.² This value was shown through the interdisciplinary rehabilitation teams who helped patients recover from severe clinical presentations of COVID-19.

Hospitals that partnered with experts to operate their inpatient rehabilitation program prior to the pandemic were often better prepared to take on the fluctuations in care, including patient volume, recruitment challenges, advanced safety protocols and new therapies for COVID-19 patients.

5. Streamlined Patient Care Path

As stated in the guide, "10 Steps to Optimize Your Rehabilitation Unit," research notes that rehabilitation therapy services are expected to continue to grow following COVID-19 through 2028. With this expected growth, it is important to evaluate where patients are going to receive rehabilitative care and where there is an opportunity to keep patients within the system.

Expanding post-acute services within the hospital's care continuum enables the hospital to have more control over outcomes, reduce care transitions and helps maintain patient satisfaction throughout the care journey.

How Partnership Can Help with Hospital Financial Performance

Partnering with a focused rehabilitation expert can ease the burden of managing inpatient rehabilitation, increase patient access, and help improve clinical quality and operational efficiency – all of which will ultimately help the hospital achieve greater financial performance.

To learn how partnership can help your hospital reach its strategic goals, visit [KindredRehab.com](https://www.kindredrehab.com).

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Natalie Lamberton,
FACHE

Rebounding From Stressful Situations

When thinking about next career steps, consider the pandemic's lessons.

Professional growth requires experiencing challenges, and these past two-and-a-half years have been fraught with them. Within the new landscape, it may be prudent for healthcare leaders to take a step back and reflect on our careers.

True growth and success can be obtained only through introspection. It requires humility to truly reflect, extract learnings from adversity and grow as a result. Things that worked in the past might not serve you well now. Following is advice for considering one's career trajectory in this new environment.

Make a List

Take an inventory of your competencies, including those gained during the pandemic. The list will most likely include resilience, tenacity and patience, among others. It's important to ask yourself: What has been gained during this tough period? What new competency have I learned that I can use to propel my healthcare career forward?

Give Yourself Grace

When we are in hard times, it's easy to think we can operate at full capacity as we are so often used to doing. What we need, however, is to give ourselves permission to forgive any mistakes we might have made

during this challenging time—during which we have all tried to do our best—to take the time to recover from recent events, and to rest. A lesson learned for many athletes is that when you suffer an injury, it's so tempting to push through and try to maintain a normal training regimen. This is often ineffective, however, and dangerous. It can further exacerbate an existing injury and potentially cause additional, even irreparable, harm.

For leaders it's acceptable, and necessary, to slow down. Give healing and recovery its due time, and process recent challenging events. As naturally competitive people, athletes often return to baseline as soon as possible. This is true of leaders, as well. Instead, identify that we need to mend things and then have the discipline to do so at the appropriate speed. In addition, take the time for vital "self-care," which can come in many forms, from meditation to daily walks.

Seek Outside Counsel

When we are under pressure or stress, we tend to lack objectivity or make emotional or irrational decisions. It's important, however, to be vulnerable at times. This is often foreign territory for leaders. Try reaching out to trusted colleagues or mentors and

garner their more objective opinions about you regarding challenging situations or circumstances.

Determine what you've personally gained through this once-in-a-lifetime experience, including its obstacles and struggles.

In addition, consider engaging a professional coach, counselor or therapist to help process what has happened and determine if there are areas in your work life that need to change. Identify the root causes that created the need for change, and determine what behaviors came about as a result that may or may not need modifying. After doing this work, chart a path forward for change or recovery.

Watch Out for Your Ego

In any new venture, no one knows everything and only fools think

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they do. You might be tempted to succumb to shame and hide or mask the unvarnished reality that you are experiencing during a challenging time. However, not being honest about a difficulty you are going through can prolong your ability to address what is under the surface, potentially leading to more challenges down the road. Being emotionally intelligent means recognizing that we all have blind spots. As leaders, dealing with our blind spots head-on and getting comfortable with being uncomfortable is a solid approach. Be willing to defer to others on your team and collaborate with those whose strengths are your blind spots. This goes a long way in empowering collaboration and partnership within the team, as well.

Lead by Example

Leaders' behaviors set the tone and expectation for how others will respond and react. Key questions to consider include: Am I regularly practicing empathy? Am I authentic? Am I thoughtfully and humbly honoring the human needs of myself and those around me, or am I simply plowing through as if nothing is amiss? Do I talk about asking for help, seek counsel and forgive myself for my mistakes? Doing these things as a leader while others are watching can help normalize these types of responses among team members. In a way, it also gives staff license to look after themselves in challenging times.

Leverage Adversity for Good

Take advantage of the opportunity to reconsider, rethink and reengineer your own habits or processes, or

those of your department, organization or system. What have you learned? What can you shed and replace with a new, better system? Again, write this down and make the next steps of your career intentional.

Develop strategies based on what you've learned about yourself and your organization during the pandemic. Make sure these strategies fit your leadership style and abilities. Take the time to slow down and make a plan that reflects your learnings and growth, and resist the urge to plow forward haphazardly with doing things the old way.

Professional growth requires experiencing challenges, and these past two-and-a-half years have been fraught with them.

We've all heard the adage by Greek philosopher Heraclitus, "Change is the only constant in life." Looking for change and embracing it can alter how you feel and respond to it. Determine what you've personally gained through this once-in-a-lifetime experience, including its obstacles and struggles.

Apply these to your leadership and personal career goals, and you will not only stop fearing change, you might just learn to appreciate it. ▲

Natalie Lamberton, FACHE, is CEO, Denver Springs, Denver (natalielamberton@spsh.com).

Key Takeaways

After experiencing the challenges of these past two-and-a-half years, it's a good time for leaders to pause and reflect on their careers. Steps include:

Make a list. Take an inventory of your competencies, including those gained during the pandemic.

Give yourself grace. Forgive yourself for mistakes you might have made during this challenging time, and take time to recover from recent events and rest.

Seek outside counsel. Reach out to trusted colleagues or mentors and ask for their objective opinions about you, or consider engaging a professional coach, counselor or therapist.

Watch out for your ego. Be willing to acknowledge your blind spots and defer to others on the team who have strengths in those areas.

Lead by example. Practice empathy, be authentic and ask for help, normalizing these behaviors among staff members.



Guy M. Masters

Can Term Limits Increase Board Effectiveness?

Key insights from board chairs.

Does your board have and enforce term limits for directors? Is adhering to term limits viewed as an opportunity to refresh, reexamine and strengthen the board with new talent? Or is it something that can be extended if there “just aren’t qualified or interested candidates” available or willing to serve?

Many boards view term limits as an opportunity to attract a broader range of candidates with skills in evolving areas.

More than half (64%) of boards limit the number of consecutive terms a director may serve, and the median maximum number of terms is three, according to the Governance Institute’s *2021 Biennial Survey of Hospitals and Healthcare Systems*. The report also shows that the median term length remains three years, or four years for government-sponsored hospitals.

In PricewaterhouseCoopers’ September 2021 report, *Taking Board Governance from Good to Great: Now Is the Time to Act*, Tim Ryan, U.S. chairman and senior partner, recommends boards, “Embrace shorter board tenures. Set an expectation that at least some directors will leave after five or seven years. This can

encourage fresh thinking about renewing boards.” The report also cites an observation from executive search firm Spencer Stuart that “the pace of change and development today is so fast that perspectives can become stale.”

Tracking and Expanding Trustee Competencies

Many boards view term limits as an opportunity to attract a broader range of candidates with skills in evolving areas. These include technology, cybersecurity, population health, mergers and affiliations, change management and social media. In addition, individuals are sought who will broaden the board’s diversity and better reflect community demographics, gender, ethnicity, socioeconomic status and other valued characteristics.

Every board should have an annually updated trustee competency matrix that identifies the skills and capabilities of each board member. Updates should include board member characteristics, as well as new capability categories reflecting changes in the industry, new trends and other elements that impact hospital performance. Boards should use the competency matrix to identify potential skill gaps among its members and as screening criteria to recruit new candidates (see chart on Page 42).

Perspectives on Term Limits

Four board chairs who represent hospitals and health systems of different sizes and geographic locations weighed in on the ideal length of board term limits. Although three out of four agreed that term limits should be set and enforced, three acknowledged that challenges with board recruitment in rural areas may warrant some flexibility.

Having and enforcing term limits is an essential element to maintaining a robust, engaged board, according to Steven T. Valentine, board chair of two Los Angeles-area hospitals, CommonSpirit Northridge Hospital Medical Center and Orthopaedic Institute for Children, an alliance with UCLA Health. “We always want to maintain continuity with our boards, and this is especially important if there is turnover in senior management,” he says. “We have staggered terms and anticipate and plan for turnover in our trustees. We need new ideas and skills that fill specific evolving needs and want to avoid getting in a rut, which may happen if someone is on the board too long.”

Nevertheless, Valentine acknowledges that it’s sometimes difficult to see trustees leave at the end of their tenure, especially because of the investment of time, energy and money to keep them educated and informed about the complex healthcare field. When orienting a new trustee, Valentine ensures they are clear about expectations regarding attendance, participation and the number of meetings required, and he stresses that trustees must be prepared to actively contribute.

Jennifer Danic, former board chair at Cameron Memorial Community

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Hospital, Angola, Ind., recently “retired” from the board at the end of her third three-year term, even though the opportunity to extend her time was offered. Danic acknowledges that

“stepping aside left a hole, but it is a hole that someone else stepped into seamlessly and will bring a different perspective and skill set that is important and different from mine ...

Sometimes the longer a trustee is at the board table, the greater the tendency to get into management and operations rather than stay in the governance realm,” she says.

Sample Matrix for Board Competency Inventory

Please check the areas in which you have experience/expertise. Note additional competencies at the bottom of the table.

Competency Area	Significant	Moderate	Some
Healthcare Delivery			
Clinical Quality			
Clinical Experience			
Social Media			
Cybersecurity			
Population Health			
Performance Excellence			
Transformation, Change Management			
Transactions, Consolidation, Affiliation			
Governance			
Customer Experience			
Social Determinants of Health			
Community Health			
Technology, Systems Integration			
Fundraising, Philanthropy			
Marketing, Branding, Sales			
Finance, Accounting, Investments			
Advocacy			
Innovation			
Regulatory, Compliance			
Public Policy			
Community Activity			
Health Plan Insurance (broker, other)			
Legal			
Business Administration/Management			
Other (please note)			

However, Danic laments that board recruitment can be difficult, especially in rural areas. “It often takes several years for trustees new to healthcare to understand the industry and key elements of hospital operations and to make meaningful contributions to deliberations.” Acknowledging that it can be difficult to have conversations with trustees about retiring from the board, Danic says she has learned to be “more open, clear and specific on ‘day one’ with new board members [about] setting expectations, explaining parameters, duration of service and why there are term limits on board tenure ... constant evolution of board leadership and membership elevates the effectiveness of governance, which ultimately benefits the hospital in the long run.”

“There isn’t one best model that fits every organization; there is a balance that needs to be struck,” says Richard Evnen, former chair of the Bryan Medical Center, Lincoln, Neb., and former chair of the American Hospital Association Committee on Governance. This is especially true for rural hospitals. Evnen believes term limits create opportunities to recruit trustees with skills to address newly identified needs as changes occur in the field, and he supports the movement toward recruiting people from outside of the local market. He also believes “having clear term limits avoids potential hard feelings, especially when some trustees with significant years of service are asked to rotate off the board.”

However, in acknowledging that it is increasingly more difficult to find “good” people who are willing to serve as trustees, Evnen states, “The downside of term limits is the potential loss of ‘institutional memory,’ and change can sometimes be destabilizing when particularly good trustees term out.”

Like Danic and Evnen, Ronald Stovash, board chair at Mon Health System, Morgantown, W.Va., believes that finding trustees in rural areas can be challenging. The “pool for qualified trustees is small in rural areas ... make finding capable people difficult,” he says. Several of the hospitals in the Mon Health System have had trustees with tenures of 20 years or more. For this reason, Stovash thinks term limits may not be needed as much in rural

areas as they are in other settings. “The most important thing is not about limiting time as a trustee as it is to make sure the hospital has a balance of the right board members with expertise and willingness to effectively serve.”

The orientation time needed for a new board member is also a consideration for Stovash. “It might take two to three years because of the complexity of healthcare,” he says, adding “and institutional knowledge and experience are essential to maintaining a vibrant and engaged board regardless of tenure.” “If you have the right people, it won’t be necessary to change them out to get new perspectives; they will be able to adapt and adjust,” he adds.

Term Limits Essential to Effective Governance

The key to making term limits work in the best interests of the board, as well as for individual trustees, is to use them as a means to an end and not simply an end in and of themselves. By establishing the core first and dealing with exceptions as needed, clearly defined and understood term limits can be a cornerstone of effective governance to ensure continuity, enable rejuvenation through resiliency, and create sustainability and success into the future. ▲

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Jim Kendig

When Violence Follows Staff to Work

This issue needs to be treated as one connected to safety culture.

In one of the most violent incidents ever recorded in healthcare, an ED doctor was gunned down in a parking lot at Mercy Hospital & Medical Center in Chicago in 2018 while a van full of nursing home patients watched in horror.

Three other people were killed in that incident, including a security guard, a first-year pharmacy resident and a Chicago police officer. What made it particularly disturbing is that the perpetrator was identified as the former fiancée of the ED doctor killed in the shooting. The shooter asked her for his engagement ring to be returned and fired his gun six times as she tried to run back to the hospital to alert security.

Sadly, this is not the first time a domestic incident has spilled into a healthcare worker's professional life. In 2002, another medical center nurse was killed by a staff member's husband after returning from her lunch break. Twenty years ago, workplace shootings were far less common than they are today. Intimate partner violence has substantially increased over the last two decades. According to the Centers for Disease Control and Prevention, data from U.S. crime reports suggest that about 1 in 5 homicide victims are killed by an intimate partner. The

reports also found that over half of female homicide victims in the U.S. are killed by a current or former male intimate partner.

Many of these women work in the healthcare system, and violence in their personal lives often follows them into the workplace. In January 2022, workplace violence standards went into effect for all Joint Commission-accredited hospitals and critical access hospitals. (Please see sidebar on Page 46 for details on these standard requirements.)

Identifying Intimate Partner Violence

Also, in January of this year, The Joint Commission published *Quick Safety, Issue 63: Addressing Intimate Partner Violence and Helping to Protect Patients*. This issue was thrust into the spotlight after medical professionals began voicing concerns about unreported child abuse, domestic abuse and intimate partner violence during the COVID-19 pandemic.

Accredited organizations are required in *standard PC 01.02.09* to use written criteria to identify patients who may be victims of:

- Physical assault.
- Sexual assault.

- Sexual molestation.
- Domestic abuse.
- Elder or child abuse and neglect.

Some of the same tactics used to identify patients who may be victims of intimate partner violence can also be applicable for colleagues and staff. A simple statement like, "I care, and I am concerned about your safety and the safety of your child/children. I can help connect you with counseling and support, legal resources and shelter. Would you be interested?" can go a long way.

Many organizations have a "go-to person" for intimate partner violence, and this individual can also work with staff experiencing domestic issues. It's important to keep all staff informed of what's in your organization's policies surrounding intimate partner violence and make sure the contact information for subject matter experts in the area is kept current.

Not every organization has a workplace violence subject-matter expert on staff, and some employees may actually be more comfortable reaching out to a stranger about issues with a partner. Share the local 24/7 emergency domestic violence hotline number with staff. If there isn't a local intimate partner violence provider, use the National Domestic

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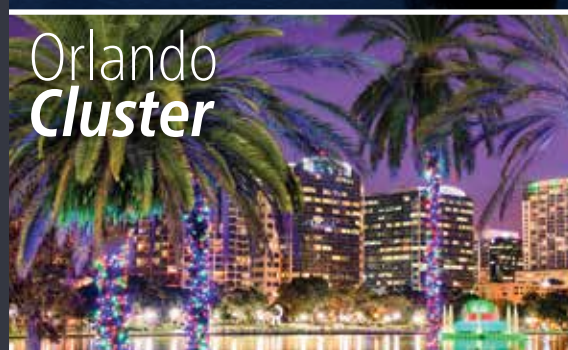
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Violence Hotline, 1-800-799-7233, which also provides excellent language translation services.

Partner With Human Resources

No department manager should be working in a silo when there is a potential for violence toward staff or patients. This is a situation that requires a great deal of diplomacy because victims are often embarrassed or worry that the suggestion of victimhood will negatively impact their career.

It's critical to keep accurate documentation on threats and potential threats.

Employees who have taken out a restraining order should inform the organization's human resources department and security department to explore possible security changes. This may be the last thing on the mind of an individual being abused, so the responsibility for sharing restraining orders often lies with supervisors or concerned colleagues. Human resources and security often request a copy of the restraining order and a photo of the individual for security purposes.

Another key role of human resources is connecting the employee with the organization's employee assistance

program, a natural fit given the correlation of intimate partner violence with staff and patient safety. EAP services usually include:

- Policy development.
- Delivery of training and seminars.
- Delivery of educational/awareness-raising activities.
- Provision of management/security staff consultation.
- Counseling to the affected employee.
- Oftentimes the most impactful changes can come from the employee's manager, who can arrange to change schedules, re-allocate the staffer to a different patient area or make other arrangements such as secure parking.

New Workplace Violence Prevention Requirements

The Joint Commission's new workplace violence prevention requirements went into effect on Jan. 1, 2022. These requirements include three new elements of performance and two revised elements of performance. These are explained thoroughly in R3 Report Issue 30: New Workplace Violence Prevention Standards and are designed to provide an accountability piece for hospitals and support reporting of violence. Highlights include:

- An annual worksite analysis that could capture additional data confidentially.
- Taking action to mitigate or abate issues as a result of the worksite analysis.
- Collecting information about safety and security incidents involving patients, staff or others, including those related to workplace violence.
- Investigating issues gathered through safety and security incidents or worksite analysis.
- Staff training and education at time of hire, annually and whenever a change occurs related to workplace violence (hospital determines training based upon staff's roles and responsibilities).
- Training required to address prevention, recognition, response and reporting.
- A program led by a designated individual and developed by a multidisciplinary team.
- Reporting to the governing body.

Security Considerations

Forewarning about the potential for a staff member's partner to create violence in the workplace is the key to preventing a deadly event. Security staff would benefit from having a photo behind the desk of anyone who could potentially present a threat.

Security could also increase their rounding in areas with potential for violence and arrange car escorts for any staff member who could be in danger. The escorts to the car are a huge deterrent for criminals, as many attackers try to find the victim alone or away from hospital security when initiating violence.

It's considerably easier for larger organizations with more resources to implement security precautions. Smaller or more rural organizations can still partner with local law enforcement or even facilities and maintenance staff.

Underreported Epidemic

The healthcare industry has learned a great deal from these violent incidents over the years, and the resulting security precautions have been extraordinarily effective. However, because intimate partner violence is so underreported among healthcare workers, organizations don't always have the opportunity to put their well-honed plans into place.

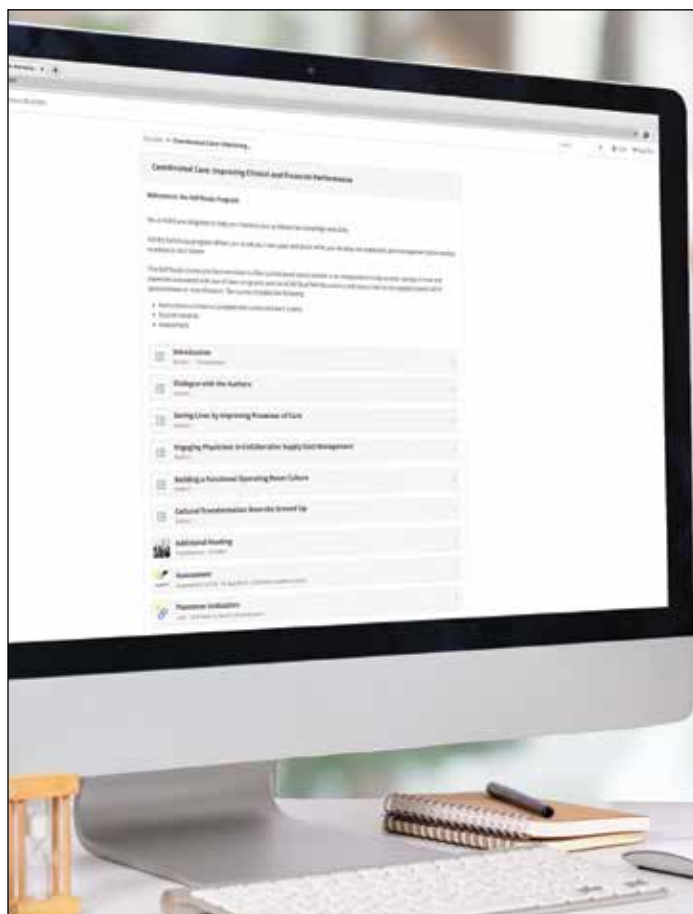
Much of the underreporting is attributed to the persistent (but false) notion that problems like intimate partner violence "don't happen in communities like ours." We'll never forget surveying in a hospital located in an affluent area when a nursing student approached the administration about posting flyers with tear-away telephone numbers for a


domestic abuse hotline. The administration supported the request but thought it was unnecessary in their demographic. Administrators were later shocked to hear that every single phone number from the tear-away flyer was removed in a few days.

Even tight-knit staffing units that may suspect a colleague is being abused often neglect to report these apprehensions to human resources or security. The only way to really resolve this issue is through further all-staff education on intimate partner violence. This is happening at the early stages with the CDC and the World Health Organization publishing statements on intimate partner violence, but now is the time to take it to the next level.

Intimate partner violence can happen to anyone, including healthcare workers. This issue needs to be treated as one connected to safety culture. Employees need to feel comfortable reporting potential violence in their own homes, and that will happen only when leadership creates a safe space to do so. Only then can we be confident that incidents like the death of the ED physician in Mercy Hospital's parking lot are something that will never be repeated. ▲

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John B. Chessare, MD,
FACHE



John Kueven, RN,
FACHE

Tried and True Strategies for Performance Excellence

Achieving system thinking requires leadership to establish clear goals and objectives.

In 2020, GBMC HealthCare, Baltimore, and Wellstar Paulding Hospital, Hiram, Ga., received the Malcolm Baldrige National Quality Award in healthcare for posting industry-leading performances, despite the ongoing pandemic.

A transparent culture in which people feel comfortable speaking up is crucial to recognizing areas of improvement.

Accomplishing this feat required a multiyear commitment to system design and a formalized leadership framework that helped the organization swiftly move toward its vision. However, achieving the Baldrige Award is not a testament to the work of the CEO, but to every member of the organization.

Embrace System Design and Foster Continual Improvement

Healthcare is a newcomer to system thinking, which the Baldrige journey promotes using to design and implement processes that achieve high reliability and reduced error, thereby saving lives.

Achieving system thinking requires leadership to establish clear goals and

objectives and to empower every team member to work daily to improve the organization. This leads to best-in-class performance in safety and quality. Error reduction and high reliability are key.

By pursuing the Baldrige criteria, a health system or hospital also commits to acknowledging imperfections and learning from them in a systematic way. Deficiencies are addressed when there is an obvious negative outcome, and initiatives to solve problems are celebrated even when they do not necessarily lead to a positive outcome. A transparent culture in which people feel comfortable speaking up is crucial to recognizing areas of improvement.

Realize Connection Between Front Office, Front Line

The GBMC and Wellstar leadership teams are committed to speaking with employees daily in a meaningful way. They ask staff members during morning huddles and other similar settings what processes or changes they are implementing to get the organization closer to its vision.

It takes a great deal of executive rounding for team members to be comfortable with the regular presence of senior leadership. Once that culture matures, employees feel more

secure, and that's when the necessary, organic discussions take place.

At GBMC, senior management visits units and departments daily with three roles:

- Say "thank you."
- Foster problem-solving, rather than solving the problems.
- Remove barriers.

By regularly communicating with staff, leadership models the level of communication needed with patients. As a result, GBMC's rating for communication with physicians is consistently in the top 10% of national hospitals, with patients feeling they are heard by their medical team.

It's also important to engage with staff beyond their job duty. Senior leaders at Wellstar practice different types of rounding. During informal rounding, they check in with staff and ask how their families are doing. During structured rounding, leaders

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sit in on visual management processes, for example, and ensure the processes align across the organization.

Wellstar also implemented rounding software and hosts daily voice-of-the-customer huddles, in which staff share stories of their “neighbors-caring-for-neighbors” culture.

These efforts led to Wellstar Paulding Hospital achieving 91% on the Great Place to Work Trust Index Survey in fiscal year 2019 and Wellstar Health System earning a place on the *Fortune* 100 Best Companies to Work For list.

The conversation continues outside hospital doors, where Wellstar Paulding Hospital’s senior executive leads biannual town hall meetings to reinforce the hospital’s culture and mission. GBMC also continually touches base with the community through earned and paid media opportunities, weekly blog posts, biweekly COVID-19 video updates along with comments posted on social media and feedback from its Patient and Family Advisory Council, among other avenues.

By implementing a tiered rounding approach and fostering open communication, leaders gain helpful insights and actionable data, and employees feel valued. The senior leaders of both organizations regularly remind their employees, “I only exist to make sure you have what you need to get the job done.”

Stay Focused as Leaders

Leadership teams should be intentional and consistent in how they lead and steadfast in what they consider to



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be important. Keeping the organization focused on its goals is key.

GBMC and Wellstar use the Lean management approach, which is embedded through the strategic planning process and in how goals are cascaded throughout the hospital. The result is that their people are working daily to improve what's happening in the hospital and to be transparent about what is working.

Throughout the Baldrige journey, GBMC senior leadership reinforced the goal of being a community-based system that could deliver the care they would want for their own loved ones to every patient, every time. This was then distilled down to four aims used to unify the team:

- The best health outcome.
- The best care experience.
- The least waste of resources.
- The most joy for those providing the care.

GBMC and Wellstar senior leaders believe the process of pursuing the Baldrige Award is more important than the award itself. It's not necessary that all team members know the Baldrige criteria. More important is putting practical, systemic strategies in place and that CEOs and senior management are consistent and disciplined in execution.

Allowing for Nimbleness

The Baldrige process teaches organizations to look at their core competencies and consider what makes them strong and different, and what would be hard for competitors to emulate. GBMC decided its core competency was redesigning care.

When the pandemic hit, previously reliable systems were gone or overwhelmed. Clinical changes, staffing challenges and mounting fear were synonymous across the healthcare management field, and health systems had to quickly redesign care.

GBMC ramped up its telemedicine offerings and opened a COVID-19 testing center with a centralized drive-through. Additional safety measures for staff and patients were put in place, and employees used technology to enable patients to communicate with loved ones.

Leadership immediately helped to address the childcare needs of staff and offered emotional and financial support. The organization also preserved time-off benefits.

At Wellstar, having systematic approaches in place allowed the organization to be nimble and reallocate staff where necessary. Because employees already knew how to communicate and engage the front-line team, they were able to maintain strong nursing retention in comparison to their peer group and leverage support agency staff. Leadership continued to foster employee engagement and maintain the company culture.

The Baldrige process equipped both organizations with the flexibility to not only meet the demands of a sudden, global health crisis but also post industry-leading performance.

The First Steps of an Ongoing Journey

When an organization begins its Baldrige journey, two key factors will set a path for success: First, understand your "Why." If it's to achieve

an award, you likely won't be successful. Second, it is important that the CEO leads the process and sets the priorities for the organization.

To begin, have senior leadership study the Baldrige criteria and create an organizational profile per the Baldrige instructions. By answering those questions, the team will come to understand its "Why," and how it is tied to its mission, vision and values.

Next, ensure all staff members know the organization's mission and vision statements. Reinforce these at new employee onboarding sessions and during interviews.

Mission, vision and value deployment, like everything else, needs a systematic approach that includes knowing where and when you're going to communicate these statements and how you're going to use and support them. As with all aspects of the organization, a disciplined, intentional approach establishes the foundation to do the important work.

Earning the Baldrige Award does not mean an organization has achieved perfection. It means that it has embraced system design to become more highly reliable, and the results show it, but there is still much work to be done. The search for perfection is never-ending. ▲

John B. Chessare, MD, FACHE, is president/CEO, GBMC HealthCare, Baltimore (jchessare@gbmc.org). John Kueven, RN, FACHE, is senior vice president/president, Wellstar Health System/president, Wellstar Cobb Hospital, Austell Ga. (John.Kueven@wellstar.org). Kueven was the president of Wellstar Paulding Hospital at the time of the Baldrige recognition.

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Kaedrea Jackson, MD,
FACHE

The Journey From the ED to the C-Suite

An emergency physician shares her expertise on transitioning to physician leadership.

For many physicians, the attraction to healthcare is born out of a love of science, a desire to help others or both. As they go through their residency and begin to practice medicine, some physicians may increasingly become interested in the business side of healthcare, realizing there are many other factors outside of that nurturing doctor-patient relationship that affect patients—affordable and accessible care, preventative approaches, community health, care delivery, etc. For physicians who want more exposure to these factors, there are many different routes they can take. This column offers guidance and recommendations for physicians who are considering embarking on the journey from physician to physician leader.

The Desire to Make a Difference

Physicians who are considering taking on leadership roles may want to start with some soul searching to determine if this is something they really want and why they want it. The desire to make a difference and the ability to think past some of the limitations in this field are key to physician leadership. Major limitations typically center around capital and staff resources.

Some ways to begin pursuing leadership opportunities include volunteering to serve on a committee, leading

an improvement project within their organization's clinical department or attending a leadership conference. However, it is important for physicians to realize that becoming a leader doesn't mean only implementing their own thoughts. Rather, it's about getting perspectives from every aspect, considering the ramifications and then forming a decision. It's a long journey, but with focus and dedication, it's possible.

When a physician realizes they are interested in the administrative aspect of healthcare, it's important to find opportunities to connect with clinical and nonclinical department leaders. Such meetings can reveal not just the "how" of strategies and plans but also the "why," which is important for understanding the reasoning behind decision-making.

Gaining Exposure to the Business of Healthcare

Joining professional organizations specific to their specialty could offer other opportunities for clinicians to gain exposure to the business side of healthcare. Finding opportunities to attend leadership development programs may also help, as such programs can be gateways to learning about other training and volunteer or job opportunities. They can also serve as opportunities to liaise with CEOs, COOs,

CFOs and other hospital executives. (See sidebar on Page 53 for three approaches C-suite and other senior-level executives can use to ensure a successful transition for physician leaders in their organizations.)

Understanding the language of medicine is learned in the classroom and exam room, but understanding the language and vision of such executives is essential to becoming one. Mentors can also help in this regard, and they do not necessarily need to be another physician.

Earning credentials, such as the FACHE®, through professional organizations can be invaluable to an aspiring physician's career progression. It's imperative that clinical healthcare professionals become more aware and knowledgeable of the economics of healthcare, market structure and the operational environment. Nonclinical education and training can provide physician leaders with the ability to look at situations differently than their other clinical colleagues. For example, the ED is seen not just as a place for acute care delivery. It is, in most instances, the front door to the hospital and an eye into the community that provides opportunities to capture market share and guide needed community interventions.

When graduating from residency, physicians can choose to search

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specifically for administrative and clinical positions, although they may not be hired as a medical director right out of residency.

Learning as They Go

With promotions to leadership roles or multiple executive positions comes increasing decision-making power. In some ways, this is similar to practicing medicine—physicians will use their fundamental training but also learn as they go. However, for clinicians who want formal training in finance, operations and management as they seek higher-level leadership roles, earning master's degrees in health administration, public administration or business administration may be an advantageous course of action.

Regardless of how many multidisciplinary meetings are held, physician leaders will find it's best to share knowledge and facilitate a free flow of information. Transformational work typically starts with aligning goals, then taking a deeper dive into the current state before building out the strategy for a future one. Being open-minded and collegial during each step is critical to that.

As a physician executive, it is still important to continue to use one's medical expertise and training in opportunities while leading and engaging with front-line staff. Although this profession is a business, the patient and their clinical outcomes and experience remain at the center of what physician leaders do. Physicians can make an impact at all levels across an organization. Their clinical input in professional standards, quality assurance, operations and process improvement cannot be

understated. Additionally, it's important to bear in mind that although the one-on-one doctor-patient relationship that initially lured many physicians to the healthcare field may shift to a less intimate relationship with many patients, the reach of a physician executive's work is multiplied, and can definitely be just as rewarding. ▲

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Editor's note: Jackson began her career as an attending physician in the ED of Kings County Hospital Center, New York. After realizing she wanted to transition to physician leadership, she earned an MBA from New York University, became board certified in healthcare management as a Fellow of ACHE and began to assume leadership roles with increasing responsibility before arriving at the positions she holds today.

Ensuring Successful Transitions for Physician Leaders

Following are three approaches senior executives can take to ensure a successful transition for physician leaders.

1. Just as aspiring physician leaders should seek out opportunities to liaise with various healthcare organization executives, senior executives can encourage physicians in leadership roles to take part in development programs that provide an understanding of the way C-suite executives think and the language they use. For example, executives might consider recommending programs that will provide "real-life" insights and training for interacting with individuals in executive roles.
2. When implementing new programs or initiatives, senior executives will find it is helpful to have truly multidisciplinary teams, such as a planning team composed of a physician, nurse and an administrator. Including other disciplines and providers would be optimal. When senior executives encourage the development of new physician executives and engage current physician leaders, the whole leadership team benefits.
3. Physicians are often accustomed to taking the lead. However, depending on their experience with administrative duties, this may be challenging. Senior executives can help by encouraging up-and-coming physician leaders to seek the expertise of other administrative leaders for guidance, advice or knowledge when they are challenged with an administrative task or an area of administrative work they don't understand. This kind of support from a senior executive can go a long way.

ACHE MEMBER UPDATE

Interim Regent Appointed



Keimig

H. John Keimig, FACHE, president/CEO, Healthcentric Advisors, Providence, R.I., has been appointed Interim Regent for Rhode Island.

Ethics Committee Update

ACHE's Ethics Committee is responsible for reviewing member grievances and recommending actions to the Board of Governors

on allegations regarding *Code of Ethics* violations. During the 2021–2022 committee year, the Ethics Committee considered four grievances concerning ACHE members. Of these, three cases continue to be under investigation and one case resulted in membership suspension.

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

addition, the committee reviews ACHE's existing Ethics Policy Statements and suggests revisions and topics for new statements.

Ethics Committee members are ACHE Fellows who are appointed by the Board of Governors; they serve confidentially, with the exception of the committee chair, whose name is made public. The *Code of Ethics*, Ethics Policy Statements and other ethics resources are available at ache.org/Ethics.

PEOPLE

American Hospital Association Recognizes ACHE Fellows and Life Fellows

During AHA's April 2022 Annual Membership Meeting in Washington, D.C., several Fellows and Life Fellows of the American College of Healthcare Executives were among those who received awards for their service to the healthcare field and for innovative approaches to providing care. They are as follows:

Distinguished Service Award

Teri G. Fontenot, LFACHE, CEO emeritus, Woman's Hospital, Baton Rouge, La., and **Kevin E. Lofton, LFACHE**, CEO emeritus, CommonSpirit Health, Chicago, were awarded AHA's 2020 and 2021 Distinguished Service Award, respectively. This award is AHA's highest honor, given to recognize significant lifetime contributions to

the nation's healthcare institutions. Presentation of the 2020 award was delayed until this year due to the pandemic.

Board of Trustees Award

Thomas F. Zenty III, LFACHE, former CEO, University Hospitals Health System, Cleveland, received AHA's 2021 Board of Trustees Award. The award is presented to individuals or groups that have made substantial and noteworthy contributions to the work of the AHA.

Award for Excellence

Col Kathy A. Naylor, FACHE, chief, Air Force Medical Service Transition Cell, U.S. Air Force, Falls Church, Va., received AHA's 2021 Award for Excellence. This award recognizes uniformed and nonuniformed federal healthcare leaders who have distinguished themselves

through singularly significant or innovative achievements and leadership that have contributed substantially to the mission of the federal health system.

Justin Ford Kimball Innovators Award

Spectrum Health, Grand Rapids, Mich., now part of the BSHS System and led by President/CEO **Christina M. Freese Decker, FACHE**, was awarded AHA's 2021 Justin Ford Kimball Innovators Award. This award recognizes people or organizations that have developed or introduced an innovative approach

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Foster G. McGaw Prize

Texas Health Resources, Arlington, Texas, led by **Barclay E. Berdan, FACHE**, CEO, won AHA's 2022 Foster G. McGaw Prize for excellence in community service. The prize is given to a healthcare organization that has shown exemplary commitment to establishing and facilitating programs that improve the overall health and well-being of its community. The McGaw Prize is sponsored by the Baxter International Foundation, AHA and its nonprofit affiliate Health Research & Educational Trust.

Member-Led Organizations Receive Gallup Exceptional Workplace Award

Three ACHE member-led organizations received the 2022 Gallup Exceptional Workplace Award, which recognizes employee engagement. They are:

- Children's Health of Texas, Dallas, led by **Christopher J. Durovich, FACHE**, president/CEO.
- Hendrick Health, Abilene, Texas, led by **Brad D. Holland, FACHE**, president/CEO.
- Sarasota (Fla.) Memorial Health Care System, led by **David Verinder**, president/CEO, and an ACHE member.

A total of 41 organizations in a variety of industries received the award.

2022 Congress Volunteer Event a Success

Sixty individuals participated in the annual Congress volunteer event, held during ACHE's 2022 Congress on Healthcare Leadership in Chicago—the first in-person Congress since 2019. This year's volunteers painted colorful panels to create large murals that will be displayed in healthcare facilities across the country. Five participants were selected at random to win a mural for display at their facility, or they could opt to have The

Foundation for Hospital Art donate it to a children's hospital. The following participants and the organizations they represent were chosen to receive the completed murals: Anamika R. Desai, FACHE, Hackensack Meridian Health, Edison, N.J.; Diamond Staton-Williams, Atrium Health, Charlotte, N.C.; Wendy DeAngelo Fuchs, FACHE, Hospital for Special Care, New Britain, Conn.; Jeff Ciontea, Trimedix, Indianapolis; and Suzanne Kaseta, MD, FACHE, Boston Children's Health Physicians, Valhalla, N.Y.



In Memoriam

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

David J. Campbell, FACHE
Grosse Pointe Shores, Mich.

David H. Jeppson, FACHE
Saint George, Utah

Stephen J. Pribyl, FACHE
Lakeville, Minn.

Richard W. Thompson, PhD, FACHE
Palm Coast, Fla.

Highlights from the American College of Healthcare Executives and the Foundation of the American College of Healthcare Executives Board of Governors meetings, held March 25, and June 26-28, 2022.

March Board of Governors Meeting

The meeting began with a summary presentation on the 2022 Congress on Healthcare Leadership. As the meeting has now taken place, we were pleased that nearly 4,000 executives and other healthcare professionals from across the country and world attended the four-day conference in Chicago. Of note, attendance was high among CEOs and other C-suite executives, as 25% of attendees were in those roles. In addition, there were 153 education sessions, with more than 300 speakers. The Board also was informed of the Virtual Leadership Symposium's success, held in April. Over 1,400 attended this two-day online event.

Business Report

ACHE remains financially solid with strong revenues and diligent expense

management. The Board reviewed and accepted the report of the Finance Committee on the 2021 financial results. As part of the Board's review of the 2021 performance, it was reported that ACHE achieved its corporate performance objectives:

- **Member/Fellow Growth: Target Achieved.** The total number of Members and Fellows as of Dec. 31, 2021, is 38,276, and the total membership is 48,311. This reflects an increase from 37,193 paid Members, and a total of 47,308 from this same time last year.
- **Member/Fellow Attrition: Threshold Achieved.** Attrition was 7,527 Members and Fellows through December 2021, compared to 7,480 through December 2020.

- **Fellows Exams Passed: Maximum Achieved.** Through Dec. 31, 2021, a total of 918 Members have attempted the Board of Governors Exam, with 607 of those passing, resulting in a 66% pass rate. Compared to 2020 at this same point in time, 355 Members attempted the Exam, with 256 passing, resulting in a 72% pass rate.
- **Earned Credits From National ACHE Face-to-Face and Virtual Face-to-Face Education: Maximum Achieved.** F2F credits earned from paid registrants totaled 100,157, mostly through the success of Congress.
- **Member Satisfaction: Threshold Achieved.** We conducted the Member Needs Survey, the primary survey sent to Members, Fellows and leaders annually. This year's satisfaction score achieved our threshold with a weighted average of 4.12.
- **Consolidated Corporate Financials: Target Achieved.** The excess (deficit) of revenues over expenses from operations of

Thank You to Our Outgoing Board Members



Michael J. Fosina,
FACHE, Immediate
Past Chair



Kurt A. Barwis,
FACHE, Governor



Brian C. Doheny,
FACHE, Governor



Michael A. Mayo,
DHA, FACHE,
Governor



Mary C. Starmann-
Harrison, FACHE,
Governor

\$1,350,687 for the year ending Dec. 31, 2021, exceeds the original target of \$(1,894,586) for a favorable variance of \$3,245,274.

President's Report

The Board reviewed an overview of ACHE's Strategic Plan investment priorities for 2022–2024. These priorities include DEI's next level strategy, FACHE and chapters. The Board remains committed to investing in ACHE's advancement of technology to serve its members.

Strategic Plan Update

The Board was given a detailed update of the 2022–2024 Strategic Plan.

Strategic Imperative: Catalyst

In our role as Catalyst, ACHE will commit to leading for equity and safety.

The Board discussed ACHE's DEI Next Level Strategy to be a thought leader and champion to drive solutions that advance equity. Currently, research is underway to inform the Board's decision in June on next steps.

Strategic Imperative: Connector

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.

It was reported to the Board that ACHE is examining new ways to enhance the ACHE-chapter partnership. The goal is to better leverage the role of chapter leaders and volunteers in providing value to members.

Strategic Imperative: Trusted Partner

In our role as Trusted Partner, ACHE will commit to deepening engagement with members and the healthcare community.

The Board discussed ACHE's FACHE Leadership Campaign that will accelerate the adoption of board certification in healthcare management as an ACHE Fellow (FACHE®) as the gold standard for leading. The Board was also given a technology assessment update, in which ACHE will accelerate the use of technology to proactively meet the challenges of a rapidly changing environment and create unparalleled digital experiences for leaders.

In Other Business

The Board approved the 2022–2023 committee assignments. ACHE and the Foundation are fortunate to have nearly 700 volunteers serving on 40 committees to represent the voice and perspective of our diverse membership base.

The Board welcomed the newly elected Chair Officers and Governors who were elected by the Council of Regents. They officially took office March 26.

- Delvecchio S. Finley, FACHE, Chair-Elect
- Noel J. Cárdenas, FACHE
- Michael K. Givens, FACHE
- Michele R. Martz, CPA, FACHE
- Dodie McElmurray, FACHE

The Board of Governors also thanked the outgoing Immediate Past Chair and Governors for their dedicated service to ACHE and its Foundation (see sidebar on Page 56).

June Board of Governors Meeting

The American College of Healthcare Executives and the Foundation of the American College of Healthcare Executives Board of Governors meetings were

expected to take place June 26–28. Please visit [HealthcareExecutive.org/BMH](https://www.healthcareexecutive.org/BMH) for a detailed and up-to-date account of the meetings. The following is an overview of what was expected to take place:

Financials

The Board will receive financial statements for the current period, and ACHE's and the Foundation of ACHE's 2021 financial audit and report to the Audit Committee. The auditors will issue an unmodified opinion regarding the financial positions of ACHE and the Foundation of ACHE.

The Board will also receive and discuss the 2022 forecast and as well as an overview of planned board-level investments and initiatives. Overall, ACHE is financially well-positioned.

2022–2024 Strategy Session

The Board will discuss the overall goals for the Strategic Plan for 2022–2024. Chief among the priorities is the continued focus on ACHE's diversity, equity and inclusion efforts, strengthening the Fellow credential, evolving ACHE support for chapters and advancement of technology to serve ACHE members.

President's Report

The Board will be given an update on the strength of the FACHE® and the organization's education and membership initiatives.

Next Meeting Planned

The next face-to-face meeting of the Board of Governors is scheduled for Dec. 5–6. Highlights of that meeting will be published in a future issue of *Healthcare Executive*. ▲

Challenges in Addressing Job Stress for Leaders

Results by ACHE's Executive Office, Research.

Healthcare worker burnout has become a critical issue for healthcare organizations, and creating a resilient workforce has become a focus for many. There have been numerous studies of burnout among physicians, nurses and other front-line healthcare workers.

In June 2021, ACHE collaborated with **Thom A. Mayer, MD, FACHE**, founder, BestPractices, medical director, NFL Players Association and executive vice president, Leadership, LogixHealth, Bedford, Mass; and Stanford University researchers **Tait Shanafelt, MD**, Jeanie & Stewart Ritchie Professor of Medicine and chief wellness officer, Stanford Medicine, director, WellMD Center, and associate dean, Stanford School of Medicine; and **Mickey Trockel, MD, PhD**, clinical associate professor, Department of Psychiatry and Behavioral Sciences, Stanford School of Medicine, to

examine burnout and other stress-related symptoms among healthcare leaders. A survey was sent to 5,670 ACHE members holding positions of department head/director and above in healthcare provider organizations. Of those, 1,269 responded, resulting in a 22% response rate among eligible respondents who received the survey.

One-third (33%) of leaders responding to the survey had burnout scores that fell into the high range. The study examined which behaviors aimed at addressing job stress were difficult for leaders to perform. The results are shown in the table below. Other research, including studies among physicians, has shown that while there are things individuals can do to address their own symptoms of burnout, organizational factors such as leadership and culture can have a significant impact on the levels of this type of fatigue in the workforce.

Healthcare leaders looking to foster engagement among executives in their organizations might consider how organizational practices, expectations and norms may be affecting the rates of leader burnout.

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

Behaviors for Addressing Job Stressors	Percent of Leaders Reporting Difficulty With Performing Behavior (N=1,181)
Unplug from email or other work communication during time off	70%
Take breaks or moments of respite during the day	53%
Take vacations or time to do other things I enjoy	51%
Keep work hours to healthy levels	49%
Take care of my own health	46%
Finding someone to talk with about the issues I face as a leader	43%
Take time for family or other meaningful relationships in my life	35%
Recognize when I am stressed	32%
Delegate and trust others to do things correctly in my absence or to decrease my workload	30%
I do not have difficulty addressing job stress in my life	5%
Other (please specify)	1%

Women belong in all places where decisions are being made.

Ruth Bader Ginsberg

The Carol Emmott Foundation is making that happen.

Join us in our mission to advance fully inclusive gender equity in healthcare leadership through institutional support and collaboration, individual fellowships and investment, and advocacy.

carolemmottfoundation.org



Antoniades



Fernandez



Hurt-Deitch



Lim



Trogman



Wedderburn

Stathis Antoniadis to president, UH Cleveland Medical Center, from COO, Lahey Hospital & Medical Center, a member of Beth Israel Lahey Health, Burlington, Mass.

Michael Elliott, PharmD, FACHE, to COO, VCU Health System, Richmond, Va., from senior vice president/chief technology officer, Centra Health, Lynchburg, Va.

Aurelio M. Fernandez, III, FACHE, to retirement from CEO, Memorial Healthcare, Hollywood, Fla. We would like to thank Aurelio for his many years of service to the healthcare field.

Sally Hurt-Deitch, RN, FACHE, to executive vice president, nursing and operations infrastructure, Ascension, St. Louis, from senior vice president, operations.

Philip Koovakada to senior vice president, Orlando (Fla.) Health South Central Region, and president, Orlando Health—Health Central Hospital, from president/CEO, St. Luke's Baptist Hospital, Baptist Health System, San Antonio.

Stephanie Lim, FACHE, to group chief strategy officer, The Palm Beach (Fla.) Health Network, from vice president, strategy,

neuroscience and innovation, HCA Healthcare Capital Division, Richmond, Va.

Thom A. Mayer, MD, FACHE, to executive vice president, leadership, LogixHealth, Bedford, Mass.

Donald R. Owrey, FACHE, to president/CEO, Atlantic General Hospital and Health System, Berlin, Md., from president, UPMC Williamsport and COO, UPMC's northern region.

Debra Potempa, RN, NEA-BC, to president, Parkview Wabash (Ind.) Hospital, from CNO/vice president, hospital operations, Mercyhealth, Janesville, Wis.

Kenneth Sturtz, FACHE, to CIO, Florida Cancer Specialists and Research Institute, St. Petersburg, Fla., from CIO, Brooks Rehabilitation, Jacksonville, Fla.

Richard Trogman, FACHE, to CEO, Stockton (Calif.) Regional Rehabilitation Hospital, Ernest Health, from COO/president, PIH Health Hospital—Downey, Whittier, Calif.

Bill Ulbricht Jr., to CEO, Baptist Hospital, Miami, from chief operating and administrative officer.

Tom VanOsdol, FACHE, to executive vice president/chief mission integration officer, Ascension, St. Louis, from senior vice president, Ascension/ministry market executive, Ascension Florida and Gulf Coast.

Joey Waddell to COO, Clark Memorial Health, Jeffersonville, Ind., from assistant administrator, Fleming County Hospital, Flemingsburg, Ky.

Tawanna Wedderburn to vice president, practice operations, IHSL, Bermuda, from clinical director, mental health services, Bermuda Hospitals Board.

Stephanie K. Wise, RN, to chief nursing executive, HCA Healthcare TriStar, Brentwood, Tenn., from, vice president/CNO, AdventHealth Shawnee Mission, Merriam, Kan.

Carla Yost, FACHE, CPHQ, to CNO, Hillcrest Medical Center, Tulsa, Okla., from CNO, Ascension/Via Christi Health, Andover, Kan.

This column is made possible in part by Exact Sciences.

**EXACT
SCIENCES**

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

Sally Belles, physician integration specialist, The Queen's Medical Center, Honolulu, received the Early Career Healthcare Executive Award from the Regent for Hawaii/Pacific.

Swati V. Bhardwaj, FACHE, director of operations, Southern Atlantic Healthcare Alliance, Cary, N.C., received the Exceptional Leadership Award from the Regent for North Carolina.

MAJ LaCharles M. Brown, FACHE, administrator, Womack Army Medical Center, Fort Bragg, N.C., received the Early Career Healthcare Executive Award from the Regent for Army.

Timothy L. Brown, DHA, human resource manager, employee engagement, Cape Fear Valley Health, Fayetteville, N.C., received the Exceptional Leadership Award from the Regent for North Carolina.

Anthony V. Cava, DHA, FACHE, president/CEO, RWJ University Hospital Somerset, Somerville, N.J., received the Lifetime Achievement Award from the Regent for New Jersey–Northern.

John B. Chessare, MD, FACHE, president/CEO, GBMC HealthCare System, Towson, Md., received the Senior-Level Healthcare Executive

Award from the Regent for Maryland.

Chad M. Collins, FACHE, director, operations, University of South Alabama Health, Mobile, Ala., received the Early Career Healthcare Executive Award from the Regent for Alabama.

Col Gregory S. Cullison, FACHE, director, medical manpower and personnel, Headquarters U.S. Air Force/SG1, received the Brig Gen James “Jay” Burks Senior Healthcare Executive/Mentor Award from the Regent for Air Force.

Rona Curphy, FACHE, CEO, The CORE Institute Specialty Hospital, Phoenix, received the Regent Award from the Regent for Arizona.

Col Martin Doperak, DO, FACHE, commander, Tripler Army Medical Center, Honolulu, received the Career Achievement Award from the Regent for Army.

Amir Farooqi, FACHE, director/CEO, Central Alabama Veterans Health Care System, Montgomery, Ala., received the Senior-Level Healthcare Executive Award from the Regent for Veterans Affairs.

Dresdene E. Flynn-White, FACHE(R), received the ACHE of North Texas Lifetime Achievement

Regent's Award from the Regent for Texas–Northern.

Patricia D. Foley, FACHE, associate vice president, access management and regulatory affairs, Children's Specialized Hospital, New Brunswick, N.J., received the Senior-Level Healthcare Executive Award from the Regent for New Jersey–Northern.

Melanie Franco, director, Atlantic Health System, Morristown, N.J., received the Early Career Healthcare Executive Award from the Regent for New Jersey–Northern.

Tina Galloway, vice president, Optum Analytics, Eden Prairie, Minn., received the Early Career Healthcare Executive Award from the Regent for North Carolina.

Monaliza Gaw, FACHE, CNO, Ascension Texas, Austin, received the East Texas ACHE Forum–Leader Extraordinaire Award from the Regent for Texas–Northern.

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

Matthew Higgins, manager, performance services, Duke Regional, Durham, N.C., received the Early Career Healthcare Executive Award from the Regent for North Carolina.

Leslie D. Hirsch, FACHE, president, Saint Peter's Healthcare System, New Brunswick, N.J., received the Lifetime Achievement Award from the Regent for New Jersey–Northern.

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

Grace E. Itiowe, MD, program chair, Brazosport College, Lake Jackson, Texas, received the Early Career Healthcare Executive Award from the Regent for Texas–Southeast.

Erica Kahl, director, growth and business development, WellSpan Health, York, Pa., received the Early Career Healthcare Executive Award from the Regent for Pennsylvania.

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

Garry W. Kauffman, FACHE, founder, owner and manager, Kauffman Consulting, Walnut Cove, N.C., received the Exceptional Leadership Award from the Regent for North Carolina.

Mason Kolbe, senior analyst, clinical programs, DaVita, Denver, received the Early Career Healthcare Executive Award from the Regent for Colorado.

Clare T. Lee, FACHE, vice president, professional and support services, Cedars-Sinai, Los Angeles, received the Senior-Level Healthcare Executive Award from the Regent for California–Southern.

Erin Lemcke-Berno, associate vice president, operations, lab and pathology, Rochester (N.Y.) Regional Health, received the Early Career

Healthcare Executive Award from the Regent for New York–Northern and Western.

Kathleen Lewis, director of pathology, LifeBridge Health System, Baltimore, received the Early Careerist Award from the Regent for Maryland.

CDR Kevin J. Lyle, FACHE, director, administration, NMRTC Annapolis (Md.), received the Senior-Level Healthcare Executive Award from the Regent for Navy.

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

C. Brett Matens, FACHE, COO, Presbyterian St. Luke's Medical Center/Rocky Mountain Hospital for Children, Denver, received the Senior-Level Healthcare Executive Award from the Regent for Colorado.

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

Bertine C. McKenna, PhD, FACHE(R), received the Senior-Level Healthcare Executive Award from the Regent for New York–Northern and Western.

Alicia McKoy, program manager, The James Comprehensive Cancer

Center, Columbus, Ohio, received the Early Career Healthcare Executive Award from the Regent for Ohio.

Elizabeth K. McNutt, FACHE, associate vice president, data analytics, RWJBarnabas Health, West Orange, N.J., received the Business Partner Award from the Regent for New Jersey–Northern.

Mona E. Miliner, FACHE, vice president, operations, Penn State Health, Hershey, Pa., received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania.

Benita K. Miller, FACHE, deputy network director/deputy CEO, VA Southeast Network, Duluth, Ga., received the Senior-Level Healthcare Executive Award from the Regent for Veterans Affairs.

DeAnna Minus-Vincent, executive vice president/chief social justice & accountability officer, RWJBarnabas Health, West Orange, N.J., received the Innovation Award from the Regent for New Jersey–Northern.

Herron Mitchell, director, Parkland Hospital, Dallas, received the Texas Northern COVID Response Champion Award from the Regent for Texas–Northern.

Lt Col Theodosia F. Montgomery, administrative and medical support squadron commander, U.S. Air Force 51st Medical Group, received the Mid-Career Healthcare Leadership Award from the Regent for Air Force.

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

Lt Col Eric Mutchie, RN, FACHE, U.S. Army, received the Senior-Level Healthcare Executive Award from the Regent for Army.

Jessica Niles, RN, clinic supervisor, Hawaii Pacific Health/Straub Medical Center, Honolulu, received the Early Career Healthcare Executive Award from the Regent for Hawaii/Pacific.

Sarah Norwood received the Early Career Healthcare Executive Award from the Regent for California–Southern.

Elizabeth Oakley, FACHE, operations administrator, provider relations/enterprise transplant center, Mayo Clinic Arizona, Phoenix, received the Regent Award from the Regent for Arizona.

Aaron M. Predum, director, biomedical engineering, Hawaii Pacific Health, Honolulu, received the Early Career Healthcare Executive Award from the Regent for Hawaii/Pacific.

Lawrence D. Prybil, PhD, LFACHE, former Norton Professor in Healthcare Leadership, University of Kentucky College of Public Health, was honored as a Public Health Legend, bestowed on behalf of the dean, University of Kentucky College of Public Health.

Ana V. Ramirez, patient relations and volunteer coordinator, Sharp Coronado (Calif.) Hospital, received

the Early Career Healthcare Executive Award from the Regent for California–Southern.

James P. Revels, service line financial manager, UC/San Diego Medical Center, received the Senior-Level Healthcare Executive Award from the Regent for California–Southern.

Cesar Rivas, strategy consultant, Children's Hospital Los Angeles, received the Early Career Healthcare Executive Award from the Regent for California–Southern.

Carol Dorn Sanders, FACHE, senior vice president, marketing, communications and development, Dispose Rx, Sanford, N.C., received the Senior-Level Healthcare Executive Award from the Regent for North Carolina.

LT Carla F. Santiago, comptroller, U.S. Navy, received the Early Career Healthcare Executive Award from the Regent for Navy.

Leonard E. Scott, FACHE, AD, systems of care, Novartis Pharmaceuticals Corporation, Cambridge, Mass., received the Outstanding Service Award from the Regent for Ohio.

Lyle E. Sheldon, FACHE, president/CEO, The University of Maryland Upper Chesapeake Medical Center, Bel Air, Md., received the Lifetime Service Award from the Regent for Maryland.

Capt Aaron Sporrer, chief, operations research and development, Air Force, received the Early Career

Healthcare Executive Award from the Regent for Air Force.

Todd V. Stepanuik, president/CEO, Middlesex Hospital Alliance, Strathroy, Ontario, received the Senior-Level Healthcare Executive Award from the Regent for Canada.

Jessica L. Taylor, FACHE, consultant and professional coach, received the Senior-Level Healthcare Executive Award from the Regent for California–Southern.

Steven Tew, associate director, strategic planning, ambulatory network, HonorHealth, Scottsdale, Ariz., received the Regent Award from the Regent for Arizona.

Hisham Valiuddin, DO, assistant medical director, Emergency Medicine, Penn Medicine, Philadelphia, received the Early Career Healthcare Executive Award from the Regent for Pennsylvania–Southeast & Southern New Jersey.

Michele M. Volpe, FACHE, CEO, Penn Presbyterian Medical Center, Philadelphia, received the Senior-Level Healthcare Executive Award from the Regent for Pennsylvania–Southeast & Southern New Jersey.

Justina L. Wells, chief, communication and outreach, North Florida/South Georgia VHS, Gainesville, Fla., received the Early Career Healthcare Executive Award from the Regent for Veterans Affairs.

HM1 Byron K. Winfree, leading petty officer, U.S. Navy, received the Enlisted Healthcare Executive Award from the Regent for Navy.

Chapters Provide Award-Winning Service

Thirty-seven chapters were recognized for their exceptional efforts in 2021.

At the 2022 Congress on Healthcare Leadership, 37 ACHE chapters received performance awards as part of the Chapter Management and Awards Program. The award-winning chapters were honored during the Malcolm T. MacEachern Memorial Lecture and Luncheon. To receive recognition, chapters must meet or exceed one or more of the four performance standards based on a tiered recognition system.

There are six awards:

1. **Board of Governors Award:** awarded to chapters that have met all four of the performance standards in the current award year.
2. **Award for Chapter Excellence:** awarded to chapters that have met three of the four performance standards in the current award year.
3. **Award of Chapter Distinction:** for chapters that have met two of the four performance standards in the current award year.
4. **Award of Chapter Merit:** awarded to chapters that have met one of the four performance standards in the current award year.

5. **Award for Sustained Chapter Excellence:** for chapters that have met three of the four performance standards for four consecutive years.

6. **Award for Sustained Performance:** for chapters that have met at least one of the four performance standards for three consecutive years.

Encouraging Exceptional Service
ACHE's Chapter Management and Awards Program recognizes the delivery of high-quality services to ACHE members at the local level. The program has the following goals:

- Create a system that compares chapter performance objectively and manages current and future success based on a common set of indicators.
- Provide well-deserved recognition to top-performing chapters. (All recognition is based on measurable outcomes of chapter performance. By providing recognition, ACHE reinforces the added value of chapter membership.)

2021 Performance Standards
ACHE uses the information from reports submitted by chapters to calculate the performance standards

that must be met for the year. These performance standards are set annually by taking a three-year average of performance at the 90th percentile level for each standard.

In 2021, chapters had to meet or exceed the following standards to receive one of the 2022 awards:

- **Education and networking performance.** This key indicator is a calculation of the number of programming hours multiplied by the number of attendees and divided by total chapter membership at the beginning of the current award year. In 2021, winning chapters were required to provide at least 14.1 hours of chapter event programming per chapter member.
- **Net membership growth.** This outcome is measured by the percentage difference between the total number of ACHE-affiliated chapter members in all membership categories at the beginning and end of the year. In 2021, winning chapters were required to have a net membership growth of at least 6.6%.
- **Level of member satisfaction.** Each chapter is expected to have a top-ranking level of member satisfaction as measured in the annual survey administered by ACHE. In 2021, winning chapters were required to receive at least a 4.2 on a 5-point scale in chapter member satisfaction.
- **Advancement of eligible members.** This outcome is measured by the percentage of an eligible pool of ACHE members affiliated with the chapter who advanced to Fellow. In 2021,

chapters needed to advance a number greater than or equal to 8.4% of the chapter members eligible to advance at the beginning of the year to receive an award.

Congratulations to Our Winning Chapters

Triangle Healthcare Executives' Forum won the Board of Governors Award; CT Association of Healthcare Executives and Puerto Rico Chapter of the American College of Healthcare Executives won the Award for Chapter Excellence; seven chapters won the Award of Chapter Distinction; 27 chapters won the Award of Chapter Merit; and 16 chapters won the Award for Sustained Performance. For a complete listing, visit [ache.org/ChapterManagementAwards](https://www.ache.org/ChapterManagementAwards).

"It is such an honor to preside over such a motivated and achieving chapter," says Michael A. Novak, FACHE, president of CT Association of Healthcare Executives, which has won the award three times now and is also a past winner of the Board of Governors Award.

"Monthly, I witness our teams of board members and chairpersons delivering solid updates and planning on what is upcoming for our chapter," he says. "One cannot help but remark at their dedication and involvement. This is quickly echoed by our membership, who see the professional value in our chapter and make our events successful. The ACHE mission is loud and strong within the Connecticut chapter, and it was the zenith of our achievement last year to once again be recognized by ACHE."

New Performance Standards

The performance standards for 2022 have been shared with the chapters. They are as follows: education and

networking performance, 12.3 hours per member; net membership growth, 6.9%; member satisfaction, 4.2 or higher (on a 5-point scale); and advancement of eligible members, 9.7%. Chapters meeting one or more of the standards will be recognized at the 2023 Congress on Healthcare Leadership in Chicago. ▲

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

We Lead for Safety

The *National Action Plan to Advance Patient Safety* and the *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.



AmericanCollege of
HealthcareExecutives®

[ache.org/Safety](https://www.ache.org/Safety)

ETHICS SELF-ASSESSMENT

Purpose of the Ethics Self-Assessment

Members of the American College of Healthcare Executives agree, as a condition of membership, to abide by ACHE's *Code of Ethics*. The *Code* provides an overall standard of conduct and includes specific standards of ethical behavior to guide healthcare executives in their professional relationships.

Based on the *Code of Ethics*, the Ethics Self-Assessment is intended for your personal use to assist you in thinking about your ethics-related leadership and actions. *It should not be returned to ACHE, nor should it be used as a tool for evaluating the ethical behavior of others.*

The Ethics Self-Assessment can help you identify those areas in which you are on strong ethical ground, areas in which you may wish to examine the basis for your responses and opportunities for further reflection. The Ethics Self-Assessment does not have a scoring mechanism, as we do not believe that ethical behavior can or should be quantified.

How to Use This Self-Assessment

We hope you find this self-assessment thought provoking and useful as a part of your reflection on applying the ACHE *Code of Ethics* to your everyday activities. You are to be commended for taking time out of your busy schedule to complete it.

Once you have finished the self-assessment, it is suggested that you review your responses, noting which questions you answered “usually,” “occasionally” and “almost never.” You may find that in some cases an answer of “usually” is satisfactory, but in other cases, such as when answering a question about protecting staff's well-being, an answer of “usually” may raise an ethical red flag.

We are confident that you will uncover few red flags where your responses are not compatible with the ACHE *Code of Ethics*. For those you may discover, you should use this as an opportunity to enhance your ethical practice and leadership by developing a specific action plan. For example, you may have noted in the self-assessment that you have not used your organization's ethics mechanism to assist you in addressing challenging ethical conflicts. As a result of this insight, you might meet with the chair of the ethics committee to better understand the committee's functions, including case consultation activities and how you might access this resource when future ethical conflicts arise.

We also want you to consider ACHE as a resource when you and your management team are confronted with difficult ethical dilemmas. Access the Ethics Toolkit, a group of practical resources that will help you understand how to integrate ethics into your organization, at [ache.org/EthicsToolkit](https://www.ache.org/EthicsToolkit). In addition, you can refer to our regular “Healthcare Management Ethics” column in *Healthcare Executive* magazine.

Please check one answer for each of the following questions.

I. LEADERSHIP	Almost Never	Occasionally	Usually	Always	Not Applicable
I take courageous, consistent and appropriate management actions to overcome barriers to achieving my organization's mission.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I place community/patient benefit over my personal gain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I strive to be a role model for ethical behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work to ensure that decisions about access to care are based primarily on medical necessity, not only on the ability to pay.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My statements and actions are consistent with professional ethical standards, including the <i>ACHE Code of Ethics</i> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My statements and actions are honest, even when circumstances would allow me to confuse the issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I advocate ethical decision-making by the board, management team and medical staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use an ethical approach to conflict resolution.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I initiate and encourage discussion of the ethical aspects of management/financial issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I initiate and promote discussion of controversial issues affecting community/patient health (e.g., domestic and community violence and decisions near the end of life).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promptly and candidly explain to internal and external stakeholders negative economic trends and encourage appropriate action.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use my authority solely to fulfill my responsibilities and not for self-interest or to further the interests of family, friends or associates.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When an ethical conflict confronts my organization or me, I am successful in finding an effective resolution process and ensuring it is followed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate respect for my colleagues, superiors and staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate my organization's vision, mission and value statements in my actions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I make timely decisions rather than delaying them to avoid difficult or politically risky choices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

II. RELATIONSHIPS

Community

I promote community health status improvement as a guiding goal of my organization and as a cornerstone of my efforts on behalf of my organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I personally devote time to developing solutions to community health problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I participate in and encourage my management team to devote personal time to community service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I engage in collaborative efforts with healthcare organizations, businesses, elected officials and others to improve the community's well-being.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek to identify, understand and eliminate health disparities in my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seek to understand and identify the social determinants of health in my community.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patients and Their Families

I use a patient- and family-centered approach to patient care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am a patient advocate on both clinical and financial matters.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ensure equitable treatment of patients, regardless of their socioeconomic status, ethnicity or payer category.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I respect the practices and customs of a diverse patient population while maintaining the organization's mission.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
I demonstrate through organizational policies and personal actions that overtreatment and undertreatment of patients is unacceptable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I protect patients' rights to autonomy through access to full, accurate information about their illnesses, treatment options, and related costs and benefits.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote a patient's right to privacy, including medical record confidentiality, and do not tolerate breaches of this confidentiality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am committed to eliminating harm in the workplace.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am committed to helping address affordability challenges in healthcare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Board</i>					
I have a routine system in place for board members to make full disclosure and reveal potential conflicts of interest.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ensure that reports to the board, my own or others', appropriately convey risks of decisions or proposed projects.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I work to keep the board focused on ethical issues of importance to the organization, community and other stakeholders.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I keep the board appropriately informed of patient safety and quality indicators.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote board discussion of resource allocation issues, particularly those where organizational and community interests may appear to be incompatible.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I keep the board appropriately informed about issues of alleged financial malfeasance, clinical malpractice and potentially litigious situations involving employees.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Colleagues and Staff</i>					
I foster discussions about ethical concerns when they arise.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I maintain confidences entrusted to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate through personal actions and organizational policies zero tolerance for any form of staff harassment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
I encourage discussions about and advocate for the implementation of the organization's code of ethics and value statements.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I fulfill the promises I make.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am respectful of views different from mine.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am respectful of individuals who differ from me in ethnicity, gender, education or job position.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I convey negative news promptly and openly, not allowing employees or others to be misled.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect and hold staff accountable for adherence to our organization's ethical standards (e.g., through performance reviews).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I demonstrate that incompetent supervision is not tolerated and make timely decisions regarding marginally performing managers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ensure adherence to ethics-related policies and practices affecting patients and staff.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sensitive to employees who have ethical concerns and facilitate resolution of these concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage the use of organizational mechanisms (e.g., an ethics committee or program) and other ethics resources to address ethical issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I act quickly and decisively when employees are not treated fairly in their relationships with other employees.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assign staff only to official duties and do not ask them to assist me with work on behalf of my family, friends or associates.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I hold all staff and clinical/business partners accountable for compliance with professional standards, including ethical behavior.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sensitive to the stress of the healthcare workforce (including physicians and other clinicians), and take steps to address personal wellness and professional fulfillment, such as incorporating these issues in employee and physician satisfaction/engagement surveys.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take steps to understand my workforce as it relates to safety, stress and burnout and consider the impact of those who are in positions of authority (including executives and physicians).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Almost Never	Occasionally	Usually	Always	Not Applicable
<i>Clinicians</i>					
When problems arise with clinical care, I ensure that the problems receive prompt attention and resolution by the responsible parties.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I insist that my organization's clinical practice guidelines are consistent with our vision, mission and value statements and ethical standards of practice.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When practice variations in care suggest quality of care is at stake, I encourage timely actions that serve patients' interests.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I insist that participating clinicians and staff live up to the terms of managed care contracts.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage clinicians to access ethics resources when ethical conflicts occur.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I encourage resource allocation that is equitable, is based on clinical needs and appropriately balances patient needs and organizational/clinical resources.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expeditiously and forthrightly deal with impaired clinicians and take necessary action when I believe a clinician is not competent to perform his/her clinical duties.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect and hold clinicians accountable for adhering to their professional and the organization's ethical practices.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Buyers, Payers and Suppliers</i>					
I negotiate and expect my management team to negotiate in good faith.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am mindful of the importance of avoiding even the appearance of wrongdoing, conflict of interest or interference with free competition.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I personally disclose and expect board members, staff members and clinicians to disclose any possible conflicts of interest before pursuing or entering into relationships with potential business partners.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I promote familiarity and compliance with organizational policies governing relationships with buyers, payers and suppliers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I set an example for others in my organization by not accepting personal gifts from suppliers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

LEADERSHIP

4 Steps to Battle Burnout and Restore Resiliency

The toll from burnout continues to be a problem for healthcare leaders, with rates above 50% in some specialties. Every measure by which quality is accessed worsens with burnout. The following steps detail how leaders address this crisis.

1. Decrease job stressors and build adaptive capacity. Burnout is simply a ratio of increasing job stressors divided by the adaptive capacity/resiliency required to deal with those stressors, which results in the three cardinal symptoms of:

- Emotional exhaustion.
- Cynicism.
- Loss of meaning at work.

2. Build leaders, increase performance recovery and start with self. Begin with these concepts:

All healthcare team members are leaders.

- Lead yourself.
- Lead your team.

All healthcare team members are performance athletes, involved in a cycle of performance, rest and recovery.

- Invest in yourself.
- Invest in your team.

The work begins within.

3. Build organizational resilience. Job stressors arise from a combination of two things (or the lack thereof), which form the basis of organizational resilience:

- A culture of passion and fulfillment.
- Hardwiring flow into the systems and processes of healthcare. Stop doing stupid stuff and start doing smart stuff.

If the culture says one thing yet exhibits another in action, and “the words on the walls” don’t match the “happenings in the walls,” that disconnect is a major source of burnout, producing cynicism. Leader rounds to identify these disconnects are essential.

Hardwiring flow in systems and processes is simple: stop doing stupid stuff and start doing smart stuff. When the current system produces burnout in half its team, it is time to redesign it. Who should do that? The people who do the work in the system, since if they aren’t with you on the take-off, they won’t be with you on the landing. That’s the path to smart stuff and away from stupid stuff.

4. Build personal resilience. “The work begins within.” As important as changing systems and processes and enacting a culture of passion and fulfillment are, it is essential to start with ourselves, since we will be called upon to redesign the system and live the culture. To be clear, this is not saying that burnout is a failure of the individual team members and their lack of resiliency (Oh, so *I’m* the problem?) In fact, the specialties with the highest resilience rates have the highest burnout rates, due to excessive job stressors. Start with these areas:

- Commit to helping your team reconnect their passion and the deep joy that brought them to healthcare.
- Rededicate your leadership team to change the culture, systems and processes as the team identifies those needed changes.
- Make the patient a part of the team, which refocuses the “why” of healthcare.
- Remind the team that self-care is critical care.

These steps are the foundation for battling burnout and restoring resiliency.

Source: From an article by Thom Mayer, MD, FACEP, FAAP, FACHE, executive vice president, leadership, LogixHealth, Bedford, Mass., and medical director, NFL Players Association.



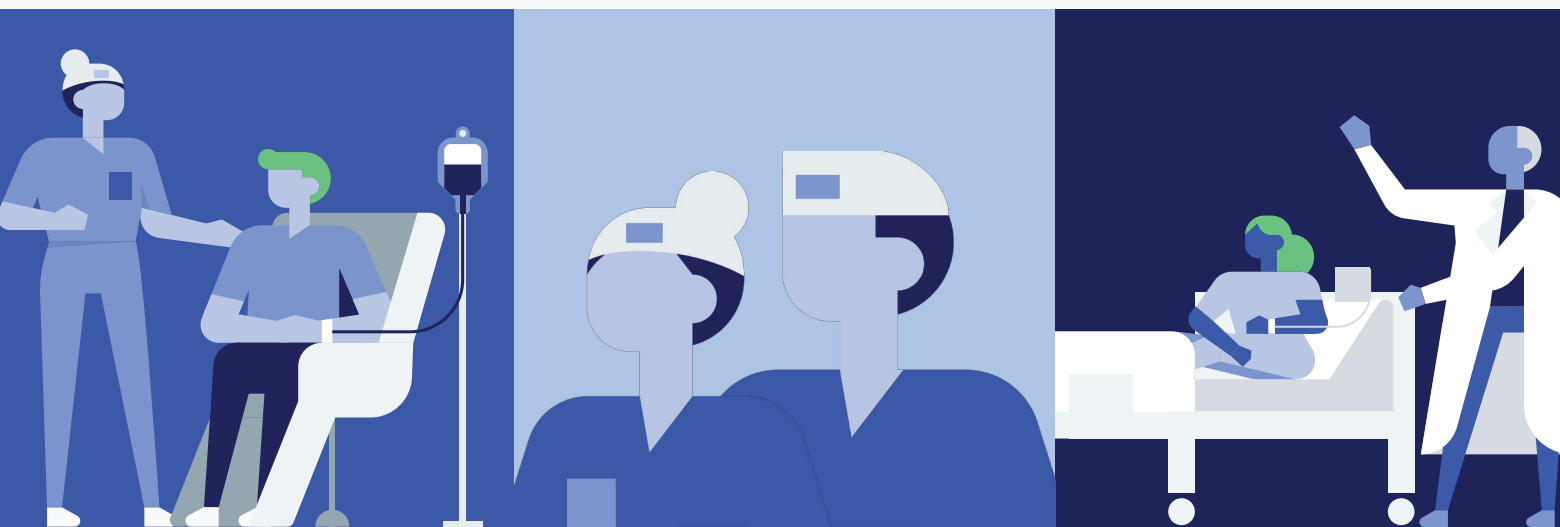
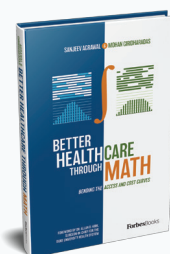
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