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To meet the supply challenges for 2023 and during the next several years, leaders stress the need for resilient infrastructures, strategic and collaborative approaches to sourcing, and skilled contracting and inventory management.

Feature

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Arguments in favor of private equity investment in healthcare make sense, while others say it puts profits above patients. Experts, however, say the reality lies somewhere in between.

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The critical role of the supply chain function in delivering high-quality patient care has once again come to light as U.S. hospitals, health systems and other care facilities continue to deal with unpredictable product shortages and quality issues.

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Tackling Financial Challenges

Randy Liss

Managing a hospital's or health system's financial performance has arguably never been as challenging as it is today. Inflation, a tight labor market, supply chain snarls and cybersecurity risks, not to mention the persistence of the pandemic, continue to be disruptive across healthcare. And there's always another crisis waiting around the corner.

"Expect the unexpected," one executive says in this issue's cover story, "Strengthening Your Supply Chain: How to Build Resiliency and Reliability Into Operations" (Page 8). That's good advice for healthcare leaders grappling with their organizations' financial dilemmas, particularly those involving the industry's supply market. In the story, we talk to leaders about their creative and strategic approaches that help them better predict and address supply shortages and bottlenecks—tactics that are paving the way toward developing a reimagined and more resilient supply chain.

Also in this issue, we delve into the topic of private equity investment in healthcare with the feature, "The Question of Private Equity" (Page 16). Executives and experts discuss the pros and cons of entering into a private equity agreement and offer advice to help organizations strike the right balance between maintaining their focus on quality and patient care and generating revenue.

On a personal note, I'm honored to now have the opportunity as *Healthcare Executive*'s editor-in-chief to share my thoughts in this column every issue. And I'm proud to work alongside the incredibly talented team that brings insights and expertise from around the field to your mailbox six times a year.

I hope you enjoy this issue, and I invite you to share your feedback with me at rliss@ache.org. Your thoughts and comments can help ensure that *Healthcare Executive* continues to serve as your trusted source of analysis on emerging trends and issues in healthcare leadership. ▲

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A 'Next Level' Strategy for DEI

Driving equity in care requires a strengthened commitment.

Deborah J. Bowen,
FACHE, CAE

January marks new beginnings. A time to recommit to our goals with new hope and energy. As your professional society, we also look to new beginnings as we launch our 2023–2025 Strategic Plan with new vigor. Most importantly, we are reminded of the need to be ever so vigilant in our quest to advance diversity, equity and inclusion, including growing the diversity of our leadership workforce. Under the vision and guidance of ACHE Board Chair Anthony "Tony" A. Armada, FACHE, the Board has elevated its commitment to do more.

DEI is woven into the fabric of who we are as an organization, and we express our commitment to it in many ways. Those expressions include national and local educational programs, scholarships for students and executives, and online communities for Asian and LGBTQ healthcare leaders. Our partnerships with others are key to leveraging our individual and collective impact.

Yet we know that boardrooms and management teams throughout our field do not reflect the communities we serve. ACHE data show that only about 16% of C-suite healthcare executives are racial minorities, even though racial and ethnic minorities make up 32% of U.S. hospital patients and 36% of the population. This

stubborn reality requires prioritizing DEI and strengthening our commitment to it in 2023 and beyond.

In executing our Strategic Plan, ACHE's Board of Governors has identified a "next level" DEI strategy to drive progress. Here is a preview of what that looks like as we activate our roles as Catalyst, Connector and Trusted Partner.

As a Catalyst, we look to drive safe and equitable care for all by identifying the knowledge, skills and abilities needed for leaders and organizations to be successful. The thought driving this focus is that the competencies required to lead toward equity in a wholistic, inclusive way may require personal insights and skills not evident in traditional paradigms. We want to drive toward a profession that integrates and advances our leadership DEI acumen alongside the core tenets of leading well to create a consolidated view of modern leadership. By identifying the learning path, we can be more intentional about our programming and curricula to advance the leadership needs of a diverse and equity-driven workforce to achieve more equitable patient care.

As a Connector, we are strengthening our commitment to our diversity

partners—the National Association of Health Services Executives, the National Association of Latino Healthcare Executives, the Institute for Diversity and Health Equity, the Better Together Collaborative, The Equity Collaborative, and other associations—by specifying how we can optimize our organizational resources and events for the benefit of our individual and collective members. Our chapters are key to connecting people to people. By strengthening support in creating an inclusive interprofessional leadership community, we gain new perspectives and more informed insights to advance ourselves and all leaders across the continuum of care.

As a Trusted Partner, we prioritize investing in our members and others through our ongoing programs, products and services, such as those available through our Learning Center and Career Resource Center available on **ache.org**. By continuing our commitment to scholarships and other resources, we remain dedicated to cultivating a diverse workforce.

Those investments also include a new column in this magazine focusing on DEI from a thought-leadership perspective. Tony Armada writes the inaugural edition of our "Diversity, Equity and Inclusion" column on Page 34, and we look forward to the viewpoints our contributors will share in that space. We remain committed to helping others reach their highest potential and to fostering inclusive environments, and the core of that commitment continues to be advancing the best health outcomes for all.

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Strengthening Your Supply Chain

How to Build Resiliency and Reliability Into Operations

By Maggie Van Dyke

Back orders on supplies used to average about 1,500 a month across Mayo Clinic, Rochester, Minn. Then everything changed in March 2020, which was followed by lockdowns, clogged ports, severe weather, war and a scarcity of raw materials—all leading to myriad supply shortages, ranging from PPE to imaging and laboratory test supplies, at Mayo and health systems across the country.

At the height of the pandemic, back orders at Mayo peaked at 8,000 a month before eventually settling down to around 5,000 a month in autumn 2022.

"We're in a better position than we were but still a long way from pre-pandemic levels," says Jim Francis, FACHE, chair, supply chain management. "Our biggest challenge is the uncertainty of the next disruption, knowing whether we can get a product or a substitute and have it delivered in a timely fashion."

Sean Poellnitz, chief resource officer, Renown Health, Reno, Nev., points to the fragile infrastructure holding up the international supply market. "The system had cracks before COVID," he says. "We had challenges with labor, logistics, political structures, the environment and raw materials. The pandemic put pressure on those cracks,

> "Our biggest challenge is the uncertainty of the next disruption, knowing whether we can get a product or a substitute and have it delivered in a timely fashion."
>
> —Jim Francis, FACHE, Mayo Clinic

causing deep breaks in the stability of the global supply chain."

Because of the immensity of the difficulties facing the global marketplace, Poellnitz believes supply chain disruptions will become the new reality for another 20 years. "It's an uncomfortable truth that a lot of people don't want to talk about. But it's where we're at."

At the same time, hospitals and health systems are gearing up for supply price increases due to global inflation as well as supply bottlenecks. A recent McKinsey & Company analysis predicts providers will have to absorb an additional $110 billion in supply and other nonlabor costs between 2022 and 2027.

How can providers meet these steep challenges? Supply chain leaders stress the need for resilient infrastructures, strategic and collaborative approaches to sourcing, skilled contracting and inventory management, and investments in data and analytics that help organizations predict and address supply shortages and bottlenecks.

"We operate in a global supply chain ecosystem that is dependent upon a large, complex network," says Amanda Chawla, FACHE, chief supply chain officer and vice president, Stanford (Calif.) Health Care. "We must transform how we operate our supply chain business to respond to the current norm, which is to expect the unexpected. We need to make sure our care teams have what they need to care for our patients."

Build a Responsive, Agile Internal Infrastructure

Given the unpredictability of supply shortages, as well as product recalls and quality issues, supply chain leaders at Renown Health are always on call. "When we get wind of any shortage, we move rapidly and go straight to the correct stakeholders," Poellnitz says. "We quickly understand our days-on-hand supplies and whether there are alternative products we could use."

The organization works with its suppliers, and operational and clinical leaders to understand the impact and create a risk mitigation plan, according to Poellnitz.

For instance, when an iodinated contrast factory shut down last spring, providers faced a severe shortage of the media used in CT scans. Supply chain leaders at Renown Health worked directly with the supplier and the health system's distribution partner to assess the risk. Simultaneously, the health system coordinated with physicians to determine, on a week-to-week basis, how to best allocate and prioritize the dwindling supplies of contrast media so that patients who needed imaging tests could get them.

"With risk mitigation, the No. 1 building block is communication," Poellnitz says.

Stanford Health has taken numerous steps to improve the health system's ability to respond and adapt to supply disruptions. One was launching a resiliency program, overseen by a dedicated supply resiliency officer. As part of the program, leaders from sourcing, logistics and other supply chain departments meet daily to review market forecasts, inventory levels and projected product shortages. These measures of disruption risk and inventory are used in determining daily actions for a proactive response, which may include a change in supplier, a substitute product, utilization management or another action.

The resiliency program was launched in 2020 in response to a recall of surgical gowns. The event inspired Stanford Medicine supply chain leaders to begin risk mapping the organization's supply chain. "We started mapping the impact of different disruptions and the mitigating efforts

and strategies required," Chawla says. "This has helped us understand our supply network and the degree of projected impact."

As a result of the work, Stanford Medicine supply chain leaders also recognized the need for more coordination with physicians and other clinicians. Chawla created two medical directors of supply chain positions. These physicians spend part of their time as dedicated dyad partners with supply chain leaders, partnering on activities ranging from data integration, value analysis, communications, shortages and much more.

The medical directors support two multidisciplinary committees recently set up to address shortages of clinical products. One task force is charged with identifying clinically acceptable equivalents to products in short supply. If no clinical equivalents are available for a product, the second work group determines how to safely alter current clinical practices. The goal is to reduce or eliminate usage of that product, as well as identify opportunities to decrease product waste.

These and other steps have helped Stanford Health successfully respond to product shortages. In late 2021, the health system's average fill rate fell to 70%, from an average above 95%. By managing utilization, seeking alternative products and using other strategies collaboratively identified by staff, Stanford Health's fill rate is now 98%.

Attain Greater Visibility

Forecasting and planning the number of specific products providers need compared with the number of products available has always been difficult in healthcare. This is due, in part, to daily variations in patient mix and volumes. The current volatility in the global supply chain has only amplified the need for more intelligence into both demand and fulfillment.

"Data has to become a core strategic asset of a healthcare organization, particularly from a supply chain standpoint," Francis says.

Thanks to its digital supply chain strategy, Mayo Clinic is successfully riding out product shortages. The health system has layered advanced data analytics tools over a variety of supply chain technologies—including point-of use technology and a product information management system—which gives supply chain leaders greater visibility

Common Supply Chain Strategies

As senior director, supply chain, Association for Health Care Resource & Materials Management, American Hospital Association, Michael Schiller has a bird's-eye view of hospital supply chain leaders' response to supply chain disturbances, as well as inflationary price increases.

Common strategies being adopted include the following, according to Schiller:

- Using freight management and order consolidation practices to reduce cost impacts of increasing fuel surcharges.

- Evaluating and reducing stock-keeping units of particular products to address unnecessary variation in inventory.

- Increasing buffer or safety stock inventories.

- Diversifying vendor portfolios or multi-sourcing for certain products. Shortening the supply chain to gain channel efficiencies (i.e., onshore or near-shore sourcing) and, in some cases, purchasing direct from the original manufacturer.

- Risk-stratifying inventory and identifying supplies deemed "critical." Collaborating with clinicians to develop contingency plans for these items.

- Identifying clinically accepted substitutions to proactively source when a primary product is unavailable.

- Engaging with the suppliers to mitigate risks: Hospital supply chain leaders prefer to include supplier supply chain leaders in meetings with account or sales representatives.

- Mapping the production and shipping of critical products, from raw materials to consumption, to gain bidirectional visibility, which can help identify and avoid bottlenecks.

"It's [supply chain disruptions will become the new reality for another 20 years] an uncomfortable truth that a lot of people don't want to talk about. But it's where we're at."

—Sean Poellnitz, Renown Health

into inventory. "By converging all these data points into a centralized system, we can proactively monitor what needs to be addressed and understand our ability to meet the needs of patients and caregivers," Francis says.

For example, for each Mayo Clinic site, supply chain leaders can see the available number of each product, burn rates (or average consumption rates), and whether a product is back ordered. By performing data analytics modeling, leaders can also obtain days-on-hand inventories based on patient mix combined with anticipated orders received. These types of insights allow supply chain staff to proactively ship product from one site to another when a shortage is anticipated.

Co-Labor With Suppliers

One positive development in the turbulent global supply market is that collaboration between providers and suppliers is increasing. "I think we're at a point with our suppliers where there's a deeper level of transparency," Poellnitz says. "The sharing of information and data is at an all-time high as we work to address challenges."

Mayo Clinic is partnering with suppliers to map out where specific supplies and the raw materials used to make those supplies originate. "We are working on gaining better bidirectional visibility up and down the supply chain," Francis says. "By understanding where a product's country of origin is and where that product is manufactured, we can better predict potential supply disruptions due to a geopolitical event or a disaster."

Mayo also co-founded a nonprofit trade association, Healthcare Industry Resiliency Cooperative, which works to increase collaboration between suppliers and providers. Members are identifying standards and best practices that will help them work together and create a more transparent and resilient supply chain.

In the same spirit of cooperation, Poellnitz embraces the concept of "co-laboring" developed by late supply chain leader Ed Harden, who served as vice president and chief supply chain officer, Froedtert Health, Milwaukee. The concept advocates partnering with suppliers to create win-wins for the hospital, the community and the supplier. One way Renown Health co-labors with suppliers is through virtual business reviews, which provide opportunities for leaders at both organizations to discuss risks and challenges such as shortages. "We especially need to know when suppliers can't fix a problem so we can properly respond," Poellnitz says.

Look at Sourcing, Contracting

In the early months of the pandemic, Stanford Health tried to address PPE and other shortages by sending a supply chain leader overseas to work with international customs brokers to directly source products. While helpful, this strategy was not enough to address the vast product disruptions the health system was facing.

In response, Stanford Health rolled out a multitude of strategies, including "dynamic sourcing." This involves understanding the market, suppliers and costs of a specific product line to determine the best sourcing strategy. Various options include buying a product from a single vendor (sole sourcing), contracting with multiple vendors for a product line (multisourcing) and seeking products manufactured in or near the United States (onshoring or near-shoring).

"A dynamic sourcing strategy is flexible and adjusted to obtain maximum value for a product line," Chawla says. "For example, we wouldn't pursue a sole-source arrangement for two-by-four bandages when the brand of bandages is not important and we can get better value with a multisource strategy."

Negotiating contracts with suppliers to address potential shortages, as well as price increases, is another strategy

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> "We are keeping more inventory of certain products, while still relying on just-in-time vendors for other inventory with greater analytics. Demand planning and demand forecasting are key to effectively managing a just-right inventory model."
>
> —Amanda Chawla, FACHE, Stanford Health Care

supply chain leaders are using. For instance, Mayo Clinic holds distributors accountable for ensuring that their self-manufactured products are delivered on time and in full. In addition, Mayo Clinic keeps inflationary price increases mostly at bay due to negotiated terms included in contracts.

"There's no doubt that manufacturers are seeking adjustments to pay for various inflationary costs that they're experiencing," Francis says. "But we've tried to contractually protect our organization from experiencing those types of adjustments through our sourcing and contracting strategies. We have long-term committed contracts that enable us to hold our inflationary costs from going up and up."

Maintain Inventory Reserves

In light of shortages, healthcare supply chain leaders are rethinking their reliance on just-in-time delivery of products. For instance, Stanford Health has adopted a "just-right" approach to product distribution and storage. "Just-right is a blend of just-in-time delivery and strategic stocking," Chawla says. "We are keeping more inventory of certain products, while still relying on just-in-time vendors for other inventory with greater analytics. Demand planning and demand forecasting are key to effectively managing a just-right inventory model."

To implement this approach, Stanford Health opened a strategic asset warehouse to help store buffer stocks of at-risk products such as those with no clinically appropriate alternatives or products that are at risk of running out due to shortages. "We have established disruption risk analytics that provide our teams with intelligence, allowing us to focus on products with the greatest risks. When our hospitals can't get needed products in, we can rotate them in from our strategic asset warehouse," Chawla says.

Support People

Like everyone working in healthcare, supply chain employees have experienced tremendous challenges. "COVID has changed the way we work and the way we approach work," says Michael Schiller, senior director, supply chain, American Hospital Association, Association for Health Care Resource & Materials Management, Chicago. "Labor constraints and cultural issues, such as remote versus on-site work requirements, will continue to be seismic shifts in the workforce for the next several years."

Prioritizing the well-being of employees and staff is the No. 1 strategy that healthcare leaders can embrace to ensure a reliable supply chain, Poellnitz stresses. "If you have a work environment that is positive, you can retain talent who will then drive solutions and innovation."

An advocate of rounding, Poellnitz visits with various supply chain teams (e.g., central supply, sourcing) across different work shifts. "I meet with these groups online or in person and make sure they know that I understand their challenges and that they feel recognized," he says.

Schiller commends the supply chain attainments achieved across U.S. hospitals during extremely challenging times. "Supply chain professionals, by nature, are resilient. They are creative problem solvers and strategic thinkers. I am confident that the resiliency and collaboration displayed across the healthcare field these past two-and-a-half years and the work between the public-private sectors is setting the foundation for us to build a reimagined and resilient healthcare supply chain."

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

The Question of Private Equity

by Susan Birk

Arguments in favor of private equity investment in healthcare make sense.

Advocates contend that private equity groups have the necessary business expertise and the capital to eliminate waste and fragmentation, fuel innovation, improve quality, and generate substantial returns for providers and investors in a relatively short time frame.

Then there are others who claim that private investment is usurping healthcare, and that private investors' dogged pursuit of profits can relegate patients to second place and push competitors out of the marketplace.

Kaiser Health News, for example, reports that private acquisitions in healthcare often fly under the radar of federal regulators and that this lack of scrutiny and private equity's inherent focus on returns raise questions about quality shortcuts and rising costs.

A study by health economists from Johns Hopkins University and others in the Sept. 2, 2022, issue of *JAMA* found that within a large, commercially insured population, private equity acquisitions of physician practices were associated with increased spending and utilization.

Another study of private equity hospital acquisitions between 2005 and 2014 that appeared in the April 2022 issue of *Health Affairs* showed a reduction in costs per adjusted discharge but an increase in operating margins.

So, which is it then?

Experts say the reality lies somewhere in between. Indeed, there are bad actors in private equity.

The Question of Private Equity

But there are also plenty of private equity firms that appreciate the unique complexities of healthcare, believe in value-based care and population health management, and hold values squarely aligned with healthcare's Quadruple Aim. Through deals such as these, they say private equity in healthcare can drive progress and benefit all players.

What to Look for in a Partner

That's why healthcare organizations considering entering into an agreement with a private equity firm must first do the careful work of analyzing the firm's goals beyond the acquisition and the infusion of capital, according to Scott Ransom, DO, FACHE, partner, Health & Life Sciences Advisory, Oliver Wyman.

"What is their character, culture and value proposition? Is there something about their unique experience and expertise that's going to make your business better or align better with other healthcare ecosystem stakeholders?" he says. "If they're all about quality and efficiency and your incentives are aligned, that can be a very good thing. If they're all about the money without regard for value, that can be a problem."

> " If an independent medical group wants to open 10 clinics and scale for their personal success, only private equity can make that happen.
>
> **Rajiv Sharma, MD**
> physician entrepreneur, consultant and gastroenterologist

Physician entrepreneur, consultant and gastroenterologist Rajiv Sharma, MD, believes the issue is less about how the healthcare organization is owned than it is about the quality and nature of the partnership. Sharma was the sole proprietor of his corporation, Digestive Health Associates, Terra Haute, Ind., for five years before selling it to private equity in late 2021.

"Any health entity that preserves the value and trust of the doctor-patient relationship has my respect, whether it's corporate, nonprofit or private equity owned," he says. "The difference is that if an independent medical group wants to open 10 clinics and scale for their personal success, only private equity can make that happen." This is why Sharma argues that a wisely structured private equity deal can be "rocket fuel" for a practice.

Healthcare private equity's outlook remains promising even in the aftermath of the pandemic and recent economic downturn, so it behooves healthcare professionals to learn the pros and cons of a force that will influence the sector for a long time.

The Present Situation

Private investment has entered virtually every area of healthcare, from hospitals and health systems, ambulatory surgery centers, imaging centers, medical practices and specialty groups to medical devices, pharmaceuticals and biotechnology, healthcare technology systems, billing, coding, staffing and, more recently, consulting and value-based care.

"There will always be a drive for private equity because healthcare is a $4 trillion per year pie," says Alan S. Kaplan, MD, FACHE, CEO of UW Health, the nonprofit, integrated health system of the University of Wisconsin-Madison. "It's 20% of the GDP. As long as there is that much money in healthcare, there will be people interested in investing."

In 2021, $151 billion of private equity capital entered the healthcare sector globally—more than double the amount in 2020—representing 515 deals, according to a report by Bain & Company.

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The Question of Private Equity

A more recent Oliver Wyman analysis reports a "shifting landscape" in healthcare private equity in 2022, with the number of deals in the first half of the year declining 23% from 2021. Invested capital in 2022 exceeded 2021 levels for the first and second quarters of the year, but that was due to a single deal, a $17 billion buyout of a health services company. Still, even with the potentially chilling effect of inflation, fears of a recession and other economic factors, the firm says opportunities remain for investors who approach their partnerships strategically.

> " Private equity has done a good job of reducing some areas of fragmentation in healthcare, and that consolidation can improve providers' competitive position. The problem is when that greater scale enables a physician group to negotiate higher rates with payers and then those costs are passed on to consumers and employers, adding to the cost of healthcare services.
>
> Scott Ransom, DO, FACHE
> Oliver Wyman

The opportunities to tackle healthcare inefficiencies and improve quality; boost provider negotiating power with payers, suppliers and pharmaceutical companies through consolidation while enhancing value; and improve consumer satisfaction with healthcare delivery are private equity's "sweet spot," says Ransom. Though investors moved more cautiously in 2022, healthcare remains the fastest-growing sector for private investment, he says.

Long-term trends, including the increase in chronic disease prevalence with the aging baby boomer population and the many healthcare subsectors that are ripe for consolidation, have created a perfect storm of opportunity for private equity investors.

"Though activity cooled slightly in 2022, investors still see healthcare as a recession-proof growth industry," notes Todd A. Zigrang, FACHE, president of Health Capital Consultants, St. Louis, a firm that guides both healthcare providers and private equity firms through the due diligence and valuation processes of private equity transactions. "Demand for healthcare services didn't decrease during the pandemic; it increased. That's attractive to investors."

The numbers show that healthcare private equity partnerships tend to be fruitful. An analysis of data from 2010 through 2021 by Bain & Company revealed a median internal rate of return for healthcare private equity deals of 27.5% compared with an internal rate of return of 21.1% for deals in all other sectors.

But not everything is rosy.

Balancing the Capital With the Clinical

Healthcare's inherent "market frictions" may put consumer needs and investor goals at odds in ways unique to the sector, a study by the National Bureau of Economic Research indicates.

Among other things, the study, which focused on the impact of private equity on nursing home care, found 10% increases in 90-day mortality for

short-stay Medicare patients in private equity-owned facilities and 90-day spending increases of 11%.

Features unique to the healthcare sector, including the fact that patients often do not pay directly for services and that a web of government agencies acts as both payer and regulator, "could mean that high-powered incentives to maximize profits have detrimental implications" for patients, according to the report.

In a similar vein, Ransom adds that "private equity has done a good job of reducing some areas of fragmentation in healthcare, and that consolidation can improve providers' competitive position. The problem is when that greater scale enables a physician group to negotiate higher rates with payers and then those costs are passed on to consumers and employers, adding to the cost of healthcare services."

The upswing in healthcare private investment activity in recent years has also drawn the attention of federal regulators, who voice anticompetitive concerns.

Private equity-backed organizations are likely to undergo heightened scrutiny in coming years, particularly as it relates to the Stark Law and other fraud and abuse laws, notes Zigrang. After a period of quietly sitting back, federal regulators appear poised to act, he observes, with antitrust concerns raised by traditional hospitals and health systems—the entities that have long been under the government's watchful eye—helping to pique their interest.

"At their best, [private equity] companies can add value and help," said Andrew Forman, U.S. Deputy Assistant Attorney General for the Antitrust Division, in a 2022 speech to the American Bar Association. "But at their worst, they can extract value or try to thwart rivals—adding cost, delay and burden, while reducing quality and impeding innovation, which competition brings. That is why competition enforcement is so very important in this industry, and why the Antitrust Division feels a unique duty to safeguard the competitive process in healthcare."

On the plus side, private equity funds innovation and can enable providers to serve patients better by helping them add or strengthen key capabilities. "Who else is going to

> ## There always will be a drive for private equity because healthcare is a $4 trillion per year pie.
>
> Alan S. Kaplan, MD, FACHE
> UW Health

take that risk with startup medical device or biotech companies?" says UW Health's Kaplan.

He cites his institution's partnership with private equity-owned rehabilitation services provider LifePoint Health as an example. "If we didn't have access to their capital and market expertise, we might not have as great a rehab hospital as we do today," he says.

Done well, private equity also creates competition that can be healthy for the market and beneficial to consumers. "As a hospital provider, do I want that competition across the street? No, but it forces all of us to get better," says Kaplan.

On the other hand, since private equity exists to make money for investors, an investment that isn't generating returns could create pressure on expenses that might not be in the best interests of patients, he adds.

But Kaplan's leading criticism of private equity is its potential to thwart the integration healthcare has been working so hard to develop for the past 20 years. "At one end of the spectrum, you've got healthcare saying, 'let's integrate to become more efficient.' At the other end, you've got private equity saying, 'let's disintegrate by owning ophthalmology or ambulatory surgery, lower the unit cost of care and become more efficient at a narrow slice of the healthcare system at the expense of integration,'" he says.

Private equity also has the potential to perpetuate rather than reduce waste, Kaplan argues. A solution designed to streamline prior authorization, for example, doesn't address the complexity that caused the inefficiencies in the first place, which means "a private equity group is

The Question of Private Equity

profiting from addressing a problem, but the underlying causes of the problem persist," he says.

Still, he concedes that "private equity has so many entry points and products that you can't put a label on it." More recently, those entry points have included the introduction of products designed specifically for integration, population health management and value-based care.

Advice From the Experts

The experts interviewed for this article have several pieces of advice for healthcare organizations and medical practices exploring the possibility of entering into a private equity agreement.

Know who you are. Understand what your organization delivers to the market that others don't, advises Kaplan. Don't get distracted by novel products that distract from that core. Stick to what you and only you do best and only purchase things that enhance your services. How can you leverage private equity capital and expertise to create a symbiotic relationship that strengthens your offerings to the community?

Consider all the "what ifs." Protect yourself from the potential hazards of a private equity partnership. If the investment fails, your partner may disappear and your

> " Though activity cooled slightly in 2022, investors still see healthcare as a recession-proof growth industry.
>
> **Todd A. Zigrang, FACHE**
> Health Capital Consultants

nonprofit organization will still be standing and liable, Kaplan says.

Understand why you are interested in working with a given private equity firm, Ransom recommends. Are your practice or organizational aspirations long term or short term? What expertise beyond the capital infusion will the private equity firm provide? Do your due diligence on the private equity group's culture and track record to know whether its goals and values are likely to align with yours. Always work with experienced advisers who specialize in guiding healthcare organizations through the intricacies of private equity deals.

Consult early and often with your attorneys and investment bankers. Always involve a knowledgeable, experienced third party—your investment banker, for example—as an intermediary in your dealings with the private equity firm, urges Sharma.

Involve the medical staff. A private equity deal that involves only nonclinical executive leadership and doesn't include the participation of physicians could be detrimental to patient care and physician retention, stresses Zigrang, who has seen instances in which physicians have been asked to see twice as many patients a day to generate profits. Cost-cutting can be accomplished without jeopardizing the quality of care if changes are based on physician input and current best practices, he says.

"Private equity can offer the capital and the tools to re-engineer how healthcare is delivered by reducing inefficiency and fragmentation, but, as healthcare leaders know, that re-engineering isn't something that happens overnight," Zigrang notes. "The patience required to achieve those efficiencies could be diametrically opposed to the goals of a private equity group that is primarily interested in generating large profits quickly and selling. For this reason, I urge providers to work only with a private equity firm that demonstrates a true commitment to value-based care."

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

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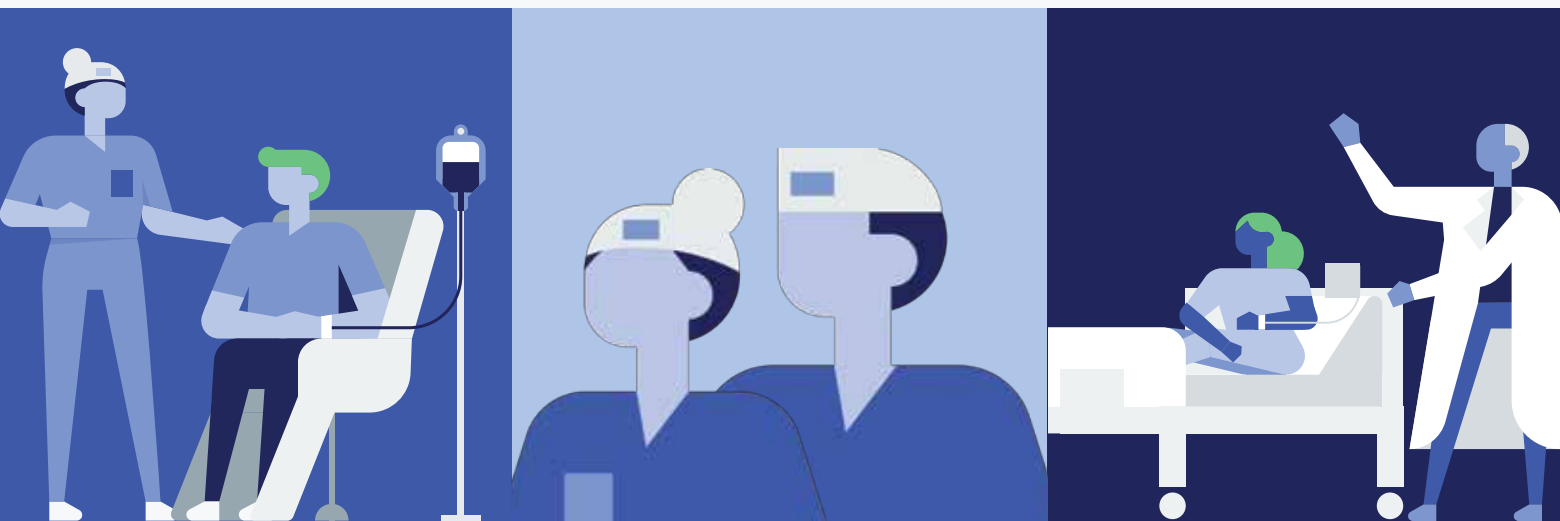
Gaining ROI From AI

Tackling today's operational challenges with artificial intelligence and machine learning.

"The fundamentals of your business … are going to be driven by machine learning and AI embedded in sophisticated experiences delivered through the patient journey. They are a necessity to become operationally efficient."

—**Sanjeev Agrawal**
President/COO
LeanTaaS
Santa Clara, Calif.

The operational challenges facing today's hospitals and health systems are many. Yet, despite investing heavily in their EHR systems, many organizations still lack the tools to do more than manually extract and decipher data that simply highlights their issues rather than drives solutions.

Innovative artificial intelligence (AI) and machine learning (ML) technologies are helping healthcare organizations harness the data housed within EHRs to address capacity and other operational issues, better manage scarce human resources, and even prevent workforce burnout, all while improving patient experience.

How AI/ML Are Improving Operations: 3 Examples
Sophisticated AI and ML technologies are all around us. Airlines use them to predict how many passengers will fly from point A to point B and then price their fares accordingly. Delivery companies use them to load millions of packages onto trucks and airplanes efficiently and deliver them all over the globe. And as healthcare organizations begin to adopt AI/ML tools more frequently, they can use them to help address common operational headaches, including:

Tackling staffing shortages. It's not uncommon for ORs across the country to underuse block time, yet they end up incurring overtime, according to Sanjeev Agrawal,

president/COO, LeanTaaS, Santa Clara, Calif. "There are chunks of time when staffed ORs are not being used, and yet those same ORs are running late into the night and require staffing after hours," he says. Predictive analytics can reveal openings to others who can fill those gaps.

AI-based solutions can help a hospital predict the number and kinds of cases that might be completed and when, which gives administrators the ability to reduce the ups and downs of clinicians' schedules that can lead to burnout. Agrawal uses a popular COVID-era term to describe this solution. "By reorganizing the schedule, you flatten the curve and add a layer of predictability in clinicians' workdays that allows them to see more patients, reduce wait times and become more efficient," he says.

As a result, their workload flattens over the course of the day, which lessens the stress on clinicians. "There are times they don't have a lot of cases, and there are times when they have to work overtime to accommodate caseload," Agrawal says. "Scheduling appropriately is a workforce-satisfaction success."

Addressing inpatient bed capacity. Artificial intelligence and machine learning tools improve predictability of length of stay and provide insights into which sets of patients are most likely to be discharged. "With AI, we can 'bucket' patients currently in beds with other people who medically resembled them when they were in the hospital and provide far better recommendations." Better predictions about patients' discharge dates can lead to better management of throughput across hospitals, as well.

Improving patient scheduling. Backlogs of patients who have delayed care during the pandemic and ongoing clinician shortages continue to trouble healthcare providers, with many patients waiting weeks or even months to schedule appointments with primary care providers and

specialists. The problem, according to Agrawal, is not with office staff—it's with the lack of predictions for the volume and mix of patients that are likely to show up to appointments. Schedulers typically make predictions based on certain traditional rules of thumb—book longer appointments in the morning and shorter ones in the afternoon, for example. This becomes a game of Tetris that can never truly be won due to the sheer number of possibilities involved, according to Agrawal. The solution? AI-based tools that use constraint-based optimization and can work through hundreds of possibilities to provide a template of sorts for medical offices to use to maximize the number of patients they can see in a day.

The Future Is Now
These technologies aren't a fad, and they're not a luxury, according to Agrawal. "The fundamentals of your business (access, cost structure, patient experience) are going to be driven by machine learning and AI embedded in sophisticated experiences delivered through the patient journey," he says. "They are a necessity to become operationally efficient."

Healthcare leaders who are planning to adopt these tools should create a budget for them that is distinct from their general IT budget, Agrawal recommends. It is like when the internet was first being adopted and everything was lumped into the "IT budget." When organizations realized that every part of the business was going to be heavily influenced by the internet, they enabled each business unit to make their own tradeoffs between spending on digitization versus hiring more people to grow and scale, according to Agrawal. Similarly with ML/AI, giving business owners the ability to improve operations and grow their business will require some "client-funded projects" instead of everything being driven centrally, he says.

And don't overlook the importance of supplier partnerships, which can provide important expertise to help hospitals or health systems get the most out of AI and ML technologies. The choice to adopt or not adopt these technologies might just come down to value. "If you think about just seeing one more patient per doctor per day or doing one more case per OR per week, that's a lot of value," Agrawal says. "The value at stake is billions of dollars in this industry."

For more information, please contact Sanjeev Agrawal, president/COO, LeanTaaS, at sanjeev.a@leantaas.com.

Transitioning From Committees to Programs

This model provides more benefits to patients, staff and communities.

Jason Lesandrini, FACHE

The past 10 years have brought to the forefront a need to rethink how healthcare organizations approach the development of an ethical culture and how this impacts the organization's response to conflicts or uncertainties about values. Historically, this work has been split among compliance and several other departments. In the early 1990s, organizations moved toward the development of ethics committees. Most acute care and some skilled nursing facilities and hospices accepted this model of developing an ethics committee to serve three core functions: ethics education, ethics policy review and development, and ethics consultation. This approach, however, has several drawbacks.

The primary challenge with an ethics committee model guided by the tripart functions is that it does not consider the way ethics integrates into the fabric of the organization. Given the growing complexity of the healthcare field, it's a good time for leaders to transition away from the narrow model of ethics committees to a broader notion of ethics programs, which focus more on building and establishing an ethical culture. The following are key components to a robust ethics program, inspired by models proposed by The Catholic Health Association and The Veterans Health Administration.

Given the growing complexity of the healthcare field, it's a good time for healthcare leaders to transition away from the narrow model of ethics committees to a broader notion of ethics programs.

Ethics Consultation
A robust ethics program includes a service staffed by appropriately trained individuals who are available and responsive to the needs of patients, families and staff and provided in a timely manner. The consultation service addresses clinical, organizational and research ethics cases in both a proactive and retroactive manner, and focuses on continuous quality improvement of the service.

Ethics Expertise
Given the complexity of work within an ethics program, it is recommended that institutions seriously consider the quality of training for program personnel. A good start is to seek out individuals who possess the Healthcare Ethics Consultation Certification, or HEC-C, that the American Society of Bioethics and Humanities offers. This certification establishes that the individual has the foundational knowledge in ethics to work with patients, families and providers to resolve conflicts or uncertainties about values. Ideally, those who lead a robust ethics program will have further certification or levels of education such as a terminal degree in a relevant field.

Ethical Research/Quality Review
A robust ethics program not only conducts research on ethics-related topics but also is involved with its organization's institutional review board, where applicable. In addition, strong ethics programs typically reflect a culture of continuous quality improvement. For example, it is recommended that an ethics program undergo an annual assessment of the ethics education offered through the program to determine if it is meeting the needs of the institution and all stakeholders.

Ethical Leadership
In a robust ethics program, there are two aspects of ethical leadership that need attention. First, it is essential that the C-suite and other top leaders support the program and raise awareness across the organization. Second, resources are made available for leaders' ethical development. These include self-assessments, conflict resolution assistance, an ethical decision-making framework for the organization and access to an ethics expert or service that can assist them in resolving ethical challenges.

Ethics Education
Like a committee model, an ethics program structure provides ethics

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Fareed Zakaria, PhD, helps audiences understand the nature of a post-pandemic world and the political, social, technological and economic consequences that may take years to unfold. In the form of 10 lessons, Zakaria will cover topics from natural and biological risks to the rise of "digital life" to emerging bipolar world order.

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education to a wide array of constituents within the organization. One role of this educational arm is to develop staff members' moral awareness, which can increase their ability to address the ethical challenges they may face. A robust ethics education program also includes a regular needs assessment, implementation and evaluation. The program also considers how ethics education could be incorporated into staff members' daily work and integrated into areas such as new employee orientation, nursing residencies or fellowships and graduate medical education.

Ethics Policy Development and Review
Under a program model, policies and procedures are regularly reviewed to ensure consistency between the policy and the organization's mission, vision and values. Historically, the scope of policy work normally considered has often been limited to clinical functions (e.g., informed consent, DNR orders, brain death), as the work of ethics committees was relegated to the clinical space. Within an ethics program approach, however, the scope of review is broader. If the program's goal is to enhance and improve the organization's ethical culture, the ethics program will need to be involved in reviewing policies across the organization, from finance (e.g., charity care) to human resources (e.g., wages and benefits) to many other areas.

Ethics Integration/Prevention
Part of a robust ethics program's goal is to ensure ethical decision-making processes are woven into the organization's cultural fabric. Examples include engaging IT

stakeholders to add ethical decision-making components to evaluation of new technologies and encouraging the integration of ethics into clinical rounds on intensive care units. Furthermore, ethics programs should implement proactive measures and processes to reduce and prevent various ethical challenges from recurring. For example, a regular review of data from the ethics consultation service may reveal that a large proportion of ethics cases focus on identifying the correct authorized decision-maker for a patient. In working to prevent these cases from arising, the ethics program could provide education on the floor or develop additional tools to assist care providers.

Ethics Outreach
A robust ethics program actively connects and engages with the community. Examples of outreach include working with local universities to provide education and partnering with them to bring new voices into the field of ethics, and working with local judicial systems to train future guardians on decision-making standards for wards of the state. In doing so, the ethics program can focus upstream and tackle issues that affect their community and potentially the organization.

Ethics Strategy/Oversight
An effective ethics program includes a mechanism for developing a robust organizational strategy that integrates with the overall strategic plan. This mechanism can provide feedback to the program as it progresses on its strategic plan and objectives, making recommendations where necessary. Some organizations have used an ethics committee in this

role, whereas others have transitioned to different structures such as system advisory groups. The program model clearly differentiates itself from the ethics committee model because it focuses on long-term plans for the program.

Ethical Culture/Climate Assessments
One key differentiator between the ethics committee model and the ethics program model is the focus on developing a robust ethical climate within the organization. As part of that development, a robust ethics program would include within its scope and role the implementation of an ethical culture assessment. Those in robust ethics programs can use this data to improve system and unit-based culture. For example, in using the data from an ethical culture survey, ethics program resources could develop action planning sessions with leaders about how they can improve their immediate culture.

Time to Transition
Developing these services can result in significant benefits to employees, patients and the organization itself. Moving toward a program-based model will require commitment from organizational leadership, and resources and public support. The benefits, however, far outweigh the costs. The time has come for organizations to re-evaluate their ethics functions and change to a program model. ▲

Jason Lesandrini, FACHE, is assistant vice president, ethics, advanced care planning and spiritual health, Wellstar Health System, Marietta, Ga., and founder and principal of The Ethics Architect (jlesandr@gmail.com).

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Reducing Readmissions

Efforts in this area for one rural community hospital are an ever-evolving journey.

Cody Utz

It is well known that care coordination is important in the management of chronic conditions, for which patients often receive care in multiple settings. Lack of communication and information sharing among healthcare entities can lead to poor patient outcomes such as preventable hospital readmissions, recurrent ED visits and medication errors. Ten years ago, the Centers for Medicare & Medicaid Services developed 30-day readmission measures to empower hospitals to evaluate and enhance the entire spectrum of healthcare for acute care patients upon hospital discharge. CMS' ultimate goal of reducing preventable hospital readmissions is to improve healthcare for Americans by linking payment to the quality of hospital care.

Today, hospitals across the United States continue to focus strategies and attention on reducing readmissions. An unplanned hospital readmission is defined as a subsequent hospital admission for any cause within 30 days following an initial stay. The Healthcare Cost and Utilization Project reported that in 2018, 3.8 million adult hospital readmissions occurred within 30 days, with an average readmission rate of 14% and an average readmission cost of $15,200. Tackling readmission reduction through quality improvement techniques is a journey rather than a one-time project. And continuous process improvement is key to sustainable change.

Patients are unique, and a one-size-fits-all approach can lead to gaps in care and, ultimately, undesired patient outcomes.

Making Readmissions a Priority
Located in America's heartland, Holton (Kan.) Community Hospital is the sole resource for inpatient care in Jackson County, population 13,232, according to the 2020 U.S. Census. The healthcare facility also offers emergency, family medicine, surgical and various outpatient services to the small town of Holton and the surrounding farming community in rural Kansas. Even though HCH, a critical access hospital, is not affected by the CMS financial penalties tied to high readmission rates, improving patient outcomes remains a top priority. The organization voluntarily participates in the Blue Cross and Blue Shield of Kansas Quality Based Reimbursement Program, which incentivizes Kansas hospitals that meet and exceed specific quality goals and benchmarks, including all-cause hospital readmissions.

Holton Community Hospital has a rich history of driving improvement initiatives that will make a positive impact on patient safety and lead to enhanced patient outcomes. In 2012, a multidisciplinary team was formed to evaluate data, incorporate innovative methodologies and implement best-practice strategies for transitional care from hospital to home. The organization had long desired to overhaul the discharge planning process. The Transitions of Care team began work on this initiative by pulling together key stakeholders from the hospital's nursing, social services, pharmacy, quality, rehabilitation and home health service areas.

The team's initial efforts focused on streamlining the discharge process and evolving communication and patient education, including incorporating the teach-back method. The Agency for Healthcare Research and Quality defines the teach-back method as checking a patient's understanding of information they received from caregivers about their health by asking the patient to state the information in their own words.

As a result, readmission rates dropped to less than 1% from 13% in the first five years after the Transitions of Care team began its work (see chart on Page 32). Over time, other quality improvement priorities took precedence, and, though the readmission

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Arthur C. Bachmeyer Memorial Address
**The Interface of Technology and Healthcare:
Positive Disruption in Consumer-Driven Solutions
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Vin Gupta, MD
Healthcare Futurist, Leading Keynote
Speaker and Expert on Healthcare Policy,
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New Health Initiatives at Amazon

The broader adoption of revolutionary digital health tools has
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are shaping the future of American healthcare delivery and
fundamentally driving increased consumerism in our
individual and collective healthcare decisions.

Malcolm T. MacEachern Memorial Address
Scenes From the Future of Healthcare
Amy Webb
World-Renowned Futurist, Founder and
CEO of the Future Today Institute

World-renowned futurist Amy Webb takes audiences
on a captivating journey as she provides a thought-
provoking series of snapshots into the prospects of
business and society. Webb will develop a set of optimistic,
neutral and chaotic scenarios that describe healthcare's
plausible scenes 10 and 20 years into the future.

Leon I. Gintzig Commemorative Address
**Passion to Purpose: The Ripple Effect of
Authentic Leadership**
Ben Nemtin
Co-founder, The Buried Life

One of the best ways to help your team gain purpose
is to connect with them around their personal and
professional goals. As the lines between personal and
professional lives blur, it's time for leaders to develop the
whole person. Join Ben Nemtin as he shares research-driven
insights into how leaders can create a ripple effect of
authentic leadership to create healthy, happy and
successful organizations.

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processes implemented remained, rates began to rise once again.

Evolving Readmissions Processes

Approaches to care are ever evolving, and to positively influence quality and performance improvement, teams must meet those changes head-on with modern concepts and practices. HCH's quality improvement leaders took note of the increase and refocused their readmission-reduction efforts, making minor changes to the process. Rates climbed to nearly 8% but are now holding steady at 4%. We believe that by continually refocusing on our efforts, rates will continue to decline. Quality data and quality priorities are analyzed and defined annually.

Our success is due in part to collaborating with patient safety and quality improvement organizations. In fact, it has been fundamental to gaining access to available resources. In Kansas, critical access hospitals collaborate through entities such as the Kansas Healthcare Collaborative and the University of Kansas Health System Care Collaborative for resource and best practice sharing.

Today, the Transitions of Care team continues to evolve and enhance its practices through customized interventions that support patients and families in the transition from hospital to the home environment. Patients are unique, and a one-size-fits-all approach can lead to gaps in care and, ultimately, undesired patient outcomes.

The addition of a second patient care coordinator (a registered nurse position that supports inpatient care with discharge coordination and performs utilization review) led to a series of concerted efforts to positively affect patient transitions. Examples of these efforts include committing to follow-up phone calls to patients, developing a customized readmissions risk-assessment tool and ensuring that post-discharge appointments are scheduled. The primary focus of the patient care coordinator position is to oversee and coordinate observation, inpatient and swing bed care with discharge planning and utilization management activities. Patient care coordinators get to know patients in a way that supports identifying social determinants of health and addressing

medication comprehension and other potential health literacy barriers.

Patient care coordinators facilitate supportive resources and navigate efficient patient movement through the continuum of healthcare to promote patient safety and more cost-effective care. For example, the same care coordinator who supports the patient during hospitalization calls the patient upon discharge within the first 48 hours and again three to five days later. The follow-up phone calls provide a pathway to identify any unmet patient needs and address issues before they develop into more problematic healthcare situations.

Another initiative Holton Community Hospital uses is a concentrated emphasis on post-hospital discharge follow-up appointments. Ideally, a follow-up appointment with a primary or specialty care provider is scheduled, and transportation is coordinated as needed, prior to the patient being discharged to the home setting. This is yet another example of a mechanism introduced into the quality improvement cycle to support the patient through the continuum of care.

Since 2012 when CMS first released its readmission measures, hospitals have maneuvered approaches to reduce preventable hospital readmissions. For hospitals, quality and process improvement initiatives are an ever-evolving journey comprising ongoing focus, planning, and implementation of innovative techniques and strategies in the pursuit of enhanced patient outcomes. ▲

Cody Utz is director, patient care services/ quality, at Holton (Kan.) Community Hospital (cody.utz@rhrjc.org).

Average Annual Readmission Rate
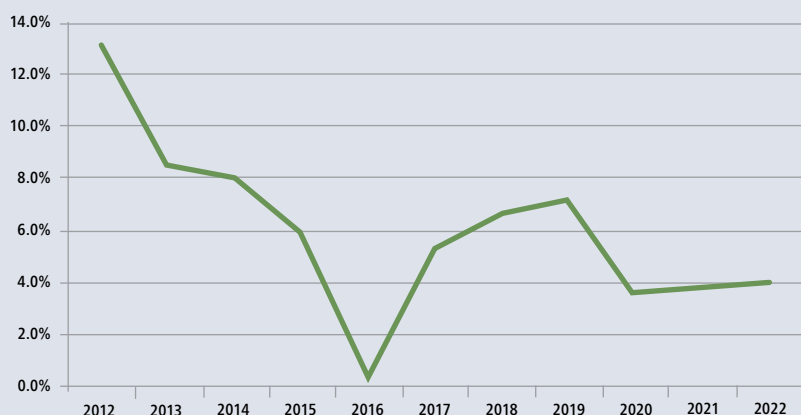
Data compiled by Holton Community Hospital.

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Coming Together on DEI

Information sharing—and leaders' passion—is essential for moving the needle on equity.

Anthony "Tony" A. Armada, FACHE

Like with all important work in healthcare, there are many examples of organizations leading the way in the field's diversity, equity and inclusion efforts: community assistance programs that promote access to care and address social determinants of health; HR policies and leadership development initiatives that foster cultural competency; and employee affinity groups that bring staff members with similar backgrounds and interests together.

In this inaugural DEI column, the following are ways to ensure your progress continues.

Commit from the top down. It's no coincidence that the organizations embracing DEI efforts strongly as a key focus area have done so starting at the highest leadership levels. One of ACHE's core values is diversity and inclusion. As members of the society that serves as the professional home for more than 48,000 healthcare leaders, you can be confident and assured that your board and CEO have not only identified DEI as a major strategic pillar but continually demonstrate that commitment through a variety of offerings, including thought-provoking educational programs and scholarship opportunities. This new column is another example of that pledge.

Similarly, in the hospitals, health systems, and care facilities and institutions we lead, our personal commitment to this issue becomes the organization's DEI foundation. And have no doubt—our communities and associates are watching to see how we create cultures of inclusion and take actions that result in real change.

Showcase and share. In so many healthcare areas (patient safety and quality, high reliability), leaders have long looked to their peers for positive examples from which to model their organizations' own efforts. They have also partnered with professional societies and academic institutions for guidance and advice, including the National Association of Health Services Executives, the National Association of Latino Healthcare Executives, the Institute for Diversity and Health Equity, the Better Together Collaborative, The Equity Collaborative, and other associations. To take it a step further, our field could benefit tremendously from a central source of information, including leading practices and tangible strategies, available to all healthcare executives and that can serve as a springboard for their DEI efforts.

Understand the why. Finally, to truly move the dial, it will take the passion of each leader to understand the *why* of DEI. This can be accomplished by deep learning of the essential impact of health equity upon patients, staff and communities. An initial question to ask is, "What services and supports will best meet the unique social, cultural and linguistic needs of those we serve?" Then, clear DEI goals and objectives can be set.

To do this, more data is essential. Similar to the idea of a central hub for displaying others' leading DEI practices and achievements, a central source of truth for data and metrics about health equity—the real numbers that tell the true story about where our organizations and the nation stand—would be invaluable. In their recent ACHE Blog post, Gayle L. Capozzalo, FACHE, executive director, The Equity Collaborative, an initiative of The Carol Emmott Foundation, and Douglas Riddle, PhD, DMin, curriculum director, The Carol Emmott Foundation, expertly make the case for why having accurate metrics about how factors such as race, ethnicity, sexual orientation, gender and disability status affect care quality and safety is so crucial to reducing care disparities.

Just as it is a trusted partner in so many other important initiatives, ACHE stands ready to partner with you in your DEI efforts. We're in this together. Our communities are counting on it. ▲

Anthony "Tony" A. Armada, FACHE, is executive vice president/chief transformation officer, Generations Healthcare Network, Lincolnwood, Ill., and ACHE Chair (aarmada@generationshcn.com).

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We invite you to share your Day of Giving stories using #ACHEGive.

The 2023 Healthcare Regulatory Agenda

A major shift in national health policy is unlikely.

Paul H. Keckley, PhD

This year, four major forces are poised to shape healthcare policies in ways that could have a consequential impact on provider organizations: the pandemic, implementation of monetary policies to lower inflation, increased opportunism for disruptors in healthcare and the 2024 presidential campaign.

In 2023, strategic private capital investing will take advantage of financial insecurity in the hospital and specialty services sectors to grow market share.

Four Major Forces
The ongoing public health emergency. The COVID-19 pandemic, first declared a public health emergency by the Trump administration in January 2020, has been renewed every 90 days since. On Oct. 14, 2022, the Biden administration extended the public health emergency through Jan. 11 and is likely to extend it again in 2023. This is significant for hospitals and public health agencies because it will permit the extension of temporary public health insurance coverage for up to 11 million people.

Implementation of monetary policies to lower inflation. The annual inflation rate hit 40-year highs twice in the last half of 2022, reaching 8.5%. The Federal Reserve's monetary policy is focused on slowing inflation to less than 2.3% by 2024 through increased interest rates. In doing so, interest rates for borrowers, including healthcare suppliers and consumers, will increase, wage growth will slow, the job market will tighten and discretionary spending for healthcare services will slow.

This could significantly impact providers because of increased media coverage of access and affordability and intensified regulator attention to provider compliance with the hospital price transparency executive order passed in 2021.

Increased opportunism for disruptors in healthcare. Even as valuations of acquisition targets slip, and initial public offerings and special purpose acquisition companies' exit portals slow, private equity funds still have $1.3 trillion of cash on hand. Companies like Amazon, CVS, Walmart, Optum and Walgreens are expanding their health portfolios in areas like self-care, senior services, mental health and more. Venture capital funding for healthcare start-ups has slowed in 2022 with lower

valuations as fund sponsors pursue deals in enhancing the profitability of portfolio companies. In 2023, strategic private capital investing will take advantage of financial insecurity in the hospital and specialty services sectors to grow market share.

The 2024 presidential campaign. The 2024 campaign season has already begun, and polls show voters are concerned about the economy, abortion and crime. Other issues specific to healthcare delivery are couched in growing voter discontent with issues like affordability, accessibility and lack of transparency. The pandemic will play a lesser role this year unless a new variant prompts public health officials to issue new directives. Protecting Medicare from insolvency and Medicaid expansion in 12 nonexpansion states will be perfunctory themes by campaigners promising solutions without detail about how they are achievable. Additionally, the Affordable Care Act will receive criticism from all sides—supporters who think it failed to make services accessible and affordable and opponents who think it's a wasteful government overreach.

Given the growing voter discontent, it is inevitable that political candidates will target hospitals and drug manufacturers, contributing to an already-increased level of scrutiny.

Federal-Level Implications
Taking into consideration these four major forces along with the composition of the 118th Congress, a major shift in national health policy in 2023 is unlikely. At the federal level, healthcare providers will

be affected most in two areas: implementation of the Inflation Reduction Act, and compliance with existing and anticipated federal agency administrative orders.

Implementation of the Inflation Reduction Act. The Inflation Reduction Act, passed by Congress in August 2022, faces headwinds because of its revenue and funding assumptions. The law presumes $739 billion in total revenue, which includes $433 billion in new spending, according to the Congressional Budget Office. This new spending includes $369 billion in climate and energy security tax credits and an additional $64 billion for a three-year extension of ACA premium tax credits.

....

At the federal level, healthcare providers will be affected most in two areas: implementation of the Inflation Reduction Act, and compliance with existing and anticipated federal agency administrative orders.

....

Popular provisions for seniors include a prescription drug out-of-pocket spending cap of $2,000 and a cap on insulin prices, but skeptics suspect its $313 deficit reduction target from "pay-fors" will not be realized. These pay-fors include a 15% minimum corporate tax, $288 billion from prescription drug pricing reforms, $124 billion from increased IRS tax enforcement and $74 billion from a 1% excise tax on corporate stock buybacks.

Compliance with federal administrative orders. Policies resulting from implementation of rulemaking by federal agencies will also be significant for providers in 2023. These include the following:

- Increased scrutiny of hospital consolidation by the Federal Trade Commission and the Department of Justice.

- Department of Health and Human Services concessions for hospitals in maintaining 340B drug discount programs.

- Simplification and modification of alternative payment models requiring participants to accept downside risk through the Center for Medicare & Medicaid Innovation.

- The Office of the National Coordinator for Health Information Technology's monitoring of compliance with core data anti-blocking interoperability requirements for electronic health information.

- HHS monitoring of compliance with the Trusted Exchange Framework and Common Agreement to advance exchange data interoperability.

- Congress' extension of the 3% Medicare payment boost for physicians through 2023 by way of the Protecting Medicare and American Farmers from Sequester Cuts Act, signed into law in 2021.

- HHS' and Department of Veterans Affairs' expansion of and coordination between mental health and substance abuse program providers, including access to telehealth services.

- The Centers for Medicare & Medicaid Services' alteration of the Medicare Advantage Star Ratings system and measures of access and equity.

- The FTC's intensified enforcement of privacy and security compliance with civil penalties and corrective actions.

State-Level Implications

In tandem with these federal administrative orders, states will play a larger role in setting policy with regard to Medicaid expansion, abortion services, scope of practice for midlevel providers, rural health services, expansion of interstate compacts for physicians, and hospital and drug price setting. Furthermore, state legislatures will also act on the integration of public health with local health systems. In some cases, the federal government will create state-level stimuli for its desired initiatives, such as Medicaid expansion and subsidies for Healthcare.gov insurance coverage.

The 2023 policy environment for healthcare providers will be challenging. There will be no additional bailout funding from the federal government this year, and operating margin erosion and encroachment by privately funded competitors will intensify. Healthcare leaders would be wise to prioritize compliance monitoring and advocacy; watchful waiting and inaction are not an option in 2023. ▲

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

Leadership Engagement, Diversity and Team Building

Expressing gratitude and focusing on self-care can give your career meaning, purpose.

Anthony J. Saul, FACHE

Colleagues in the workforce increasingly find themselves contemplating stepping away from their careers. Many believed that happiness is tied to career achievements and money but now realize that their happiness may not be tied to their professional success.

Theodore Roosevelt once said, "No one cares how much you know until they know how much you care." And in their bestselling book, *Making Work Human*, Erik Mosley and Derek Irvine purport that "Purpose, meaning, and gratitude go further than any pay scale or benefits package to create feelings of attachment among employees."

Grady Health System has taken those adages to heart, in particular within a group of high-performing, passionate financial executives who collectively manage over 900 employees. They follow the basic premise of going beyond putting in the hard work to also establishing a leadership style that is founded on the following guiding principle: to encourage and compassionately shepherd their teams.

As such, their monthly meetings often close with a reminder to "Take care of your teams, and take care of yourselves." Astute and aware leaders know deep down that to fully

succeed in their career requires heeding this for themselves and treating their own leaders with the same compassion.

Given the ubiquitous cost-consciousness at any nonprofit healthcare system, the investment in education and reenergizing the leadership team was well worth the price tag.

Leadership Retreat

Over the last few years, healthcare leaders have spent an exhaustive number of hours retooling their workforce strategies and ensuring that their employees settled into their new norms with some measure of well-being. On the business side of healthcare, that meant introducing a new paradigm to a workforce that, for the first time, was decentralized. As the realities of a newly remote workforce solidified, many companies found themselves scrambling to maintain some semblance of staff stability, while at the same time sustaining production. This meant creating new strategies to ensure cohesion, verifying handoffs and producing the same, if not better, results in a different work environment.

No longer were office-cooler talk and department rounding ways to connect with staff. Teams were separated; colleagues wondered alone what was going to happen next, in both their personal and professional lives. In this new world in which we operate, a simplified leadership approach is needed—one that focuses on self-care, gratitude and team building.

This message became the intentional driving force behind the planning of the inaugural Finance Division Leadership Retreat held offsite. The half-day retreat's goals centered on four areas: team building, leadership development, fellowship among leaders and future focus.

Team Building. The majority of the organization's finance division teams now work remotely, and for many, the retreat allowed team members to meet one another in person—some for the first time. This activity allowed for focus and clarity on how each division directly supports the next. The retreat's relaxed atmosphere allowed for significant fellowship and camaraderie, all while listening, learning and jelling together.

Leadership Development. As a leader, it is sometimes easy to forget that others are also dealing with similar challenges and departmental

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hardships, especially while working remotely. Because of this, it was important to have a speaker who could address the power of leadership, the need to identify unconscious bias, ways to serve with excellence and the importance of having difficult conversations. In turn, this openness and frank discussion allowed the retreat participants to candidly share stories and to discuss their leadership and professional challenges, personal hardships and solutions they implemented.

Fellowship Among Leaders. The word "fellowship" derives from the Greek term *koinonia*, generally meaning "to hold something in common." Before this assembly, the only commonality among many of the leaders was that they were employed at the same health system. To foster a sense of fellowship, the retreat opened with a brief meditation exercise that brought harmony to the group as they entered a peaceful state together. This exercise also encouraged leaders to let their guard down and be more receptive to the potential benefits of the activities that followed.

Future Focus. The focus is, and must always be, recognizing the leaders as individuals, identifying how they best fit into the success of the Grady Health System and insisting on their well-being. No one can pour from an empty cup, which is why self-care, gratitude and team building will continue to be the culture of this division.

Success and Next Steps
Given the ubiquitous cost-consciousness at any nonprofit healthcare system, the investment in education and reenergizing the leadership team was well worth the price tag. And the overwhelmingly positive feedback in the post-retreat evaluation affirmed the expenditure's value.

The evaluation revealed that 95% of attendees rated the retreat as excellent. It was obvious that the primary takeaway was finding ways to support and appreciate the dynamic of the individual with the goal of demonstrating their career has meaning.

It was of the utmost importance to be intentional in incorporating into the system a culture that builds up people, develops supportive teams, focuses on the purpose behind our efforts, and leaves no doubt about the value that each team member contributes to the whole. This is a certain path to combat burnout and foster an engaged, high-performing leadership team.

Though finance can be all facts and data, it is important to incorporate a culture of gratitude into teams and departments. Implementing a culture of purpose, meaning and gratitude can result in an improvement of turnover rates. To retain and reinvigorate teams, it's of paramount importance that leaders lift their members. And while we may never fully arrive at a perfect culture, the journey certainly starts with one small token of appreciation at a time. ▲

Anthony J. Saul, FACHE, is executive vice president/CFO, Grady Health System, Atlanta (asaul@gmh.edu).

Pamela R. Knecht   Sam R. Watson

Ensuring Successful Changes: A Case Study

Meaningful engagement of stakeholders is critical.

No matter the size of a healthcare organization, it is imperative to drive value and reduce variability and cost. For a health system, hospital or other care facility to transition to a value-driven approach, it's essential that the governing board(s) be aligned around the mission, be nimble and be focused on a common goal. Additionally, it's important that there be coordination across the entirety of the enterprise, otherwise known as "systemness." Having multiple governance structures in place, regardless of organizational size, can have a detrimental impact on the ability to provide value to the community. Although the following case study is from a large health system, the methods used are applicable to an organization of any size and type because the real lesson learned is the importance of using a change management approach to governance restructuring.

Spectrum Health: A Case Study
In this case study, Spectrum Health, Grand Rapids, Mich., demonstrates how it transformed governance to increase systemness and value. The original governance model comprised 11 separate governing boards charged with overseeing the organization's delivery of care. An analysis revealed that these hospital and medical group boards had 120 board members and held 324 board and committee meetings during the course of a year. These meetings accounted for nearly 4,000 hours of board member, leadership and support staff time. "As healthcare becomes even more complex, there is an increasing need to be simple and nimbler," says Tina Freese Decker, FACHE, president and CEO, Spectrum Health. "This must start with how we are governed or it has little chance of truly succeeding," she continues. It became clear there was a need to determine how the governance structure could be less unwieldly while providing more value.

Methods
Because each board was composed of committed community members and physicians with their own histories and cultures, it was important to engage them from the beginning. The organization convened a symposium with board members from each entity to hear best practices in health system governance, and to provide input on evolving from a collection of hospitals and clinics into a system.

Subsequently, a governance task force, charged with recommending a streamlined governance structure to the system board, developed a set of principles to guide the process such as "retain community voices *and* use a competency-based approach to board composition." (See sidebar on this page.)

The task force then reviewed an external expert's peer organization governance designs. Next, staff developed six models for the task force's

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Spectrum Health West Michigan Board's Governance Change Principles

1. Retain community voices and use a competency-based approach to board composition.
2. Maximize the value of board members and staff in board meetings.
3. Focus on strategy, markets and patient experience.
4. Reduce meeting burden by moving to quarterly meetings.
5. Ensure that important work occurs in board meetings.
6. Adopt flexible bylaws to allow for agility to respond to governance needs.
7. Create an escalation process for use in emergencies.
8. Be attractive to future partners.

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consideration. Before providing models, staff had considered legal and regulatory requirements, such as medical staff governance structure, medical group compensation processes, and post-acute care governance. The proposed models ranged from decentralized to centralized. The members of the task force then identified the benefits and challenges of each model.

Once the task force had selected a preferred governance model, feedback was secured from each board. The task force incorporated the ideas into final recommendations made to the system board. Then, the organization convened a second symposium, where all the boards agreed on the final structure and how changes would be implemented. This second gathering was important so that each board member felt valued, and all stakeholders believed the new structure gave them sufficient "voice" (i.e., physician, community, regions).

In addition to analyzing various governance models, the task force discussed immediate changes to streamline and coordinate the boards' work. These changes, called "just do its," included standardization of:

- Board orientation and continuing education.
- Board and committee meeting frequency and agendas.
- Governance documents, practices and support.

As the larger work of the task force progressed, staff implemented the just-do-it changes in coordination with the existing boards.

Ultimately, the governance task force recommended all 11 boards be combined into one fiduciary "mirror" board—a legal structure in which the members of one board serve as the board members of multiple corporations—called the Spectrum Health West Michigan Board. The board included a Community Leadership Committee with representatives from each advisory community board. The existing boards became advisory community boards with significant importance, but no fiduciary duties. The task force also identified the competencies for the new, 15-member SHWM Board and oversaw a process for identifying its new members.

Transparency and Socialization
Transparency in the process was critical. Each step of the change process included "socializing" with each existing board. The task force representative from each board shared the latest information and timeline, requesting input from their "home board." A standardized presentation and talking points provided a consistent message. Feedback was assembled and shared with the task force after each board cycle. As a result, each board approved the task force's recommendations, and the stakeholders remained supportive of the new design.

Results and Success Factors
"Our new governance structure has been an incredible success," says Darryl Elmouchi, MD, president of SHWM. "It helped us move quickly to respond to the needs of the community during the pandemic and beyond." On a practical level, annual board and committee meetings were reduced to 68, which decreased meeting time to less than 200 hours a year.

The factors that led to Spectrum Health's governance restructuring success can be applied to any organization. Those lessons learned include the following:

- Engage all who could be impacted throughout the whole process.
- Educate stakeholders on the reasons for change and recognized best practices.
- Create a task force that reflects all needed perspectives.
- Develop a set of principles to guide the work.
- Provide examples from peer organizations.
- Develop options to consider based on legal and regulatory reviews.
- Discuss pros and cons of each option.
- Refine recommendations with stakeholder feedback.
- Determine which changes can be easily implemented.
- Standardize communication, socialize and be transparent.

Changing board composition, size and authority is a large change-management initiative. It's recommended that organizations take a proactive, highly participative approach to working with committed, valued individuals as they move toward the systemness that provides higher value in healthcare. ▲

Pamela R. Knecht is president/CEO of ACCORD LIMITED (pknecht@ accordlimited.com) and an ACHE Member. Sam R. Watson is senior vice president, field engagement, Michigan Health & Hospital Association, and vice chair, Spectrum Health West Michigan Board, Okemos, Mich. (swatson@mha.org), and an ACHE Member.

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Effective Quality Planning

Align and prioritize projects to achieve systemwide quality goals.

As health systems continue to move forward to address their ever-present workforce issues, it's important not to lose sight of the safety and quality "never events" that teams have worked so hard to prevent. As a refresher, we recommend returning to the teachings of W. Edwards Deming to "focus on reducing variation" and strengthening quality planning efforts.

Effective quality planning engages multidisciplinary leaders in clearly defining the organization's ambitions and leverages existing data systems to identify aligned opportunities for improvement.

This article presents a useful hierarchy of variation, outlines a broad approach for health system quality planning to address variation, and shares one leader's experience (see sidebar on Page 46).

Reduce Strategic Variation With Quality Planning

Three types of variation are most common in healthcare settings and are inextricably linked: strategic, operational and clinical. Understanding different types of variation, particularly strategic variation, is helpful context for quality planning efforts.

It's also critical for organizations to address strategic variation first; it impacts improvement at the operational and clinical levels.

- *Strategic variation* generally occurs at the board and executive levels and often results in too many priorities or priorities that are not aligned with the organization's strategic goals. Engaging multidisciplinary leaders at a "10,000-foot view" using both quantitative and qualitative data, a process called quality planning, is the primary approach to minimize strategic variation.

- *Operational variation* occurs in the systems and structures meant to support the strategic goals of the organization. Workarounds often emerge to prop up old structures and problems that should be addressed with system-level changes.

- *Clinical variation* usually gets the most attention from quality improvement teams, yet these efforts to reduce clinical variation often lack rigor, are done hastily or do not effectively engage staff to yield sustainable change.

Elements of Effective Quality Planning

The Institute for Healthcare Improvement's Whole System Quality approach to overall quality management supports health systems with organizational prioritization, operational structures to support those priorities and sustained quality improvement at the front lines. Quality planning is the essential first step of a Whole System Quality approach—a process to identify the needs of patients, communities and the organization's workforce. Quality planning defines systemwide quality goals, sets priorities, responds to external evaluations of performance and ensures there are sufficient resources to meet the goals.

Effective quality planning engages multidisciplinary leaders in clearly defining the organization's ambitions and leverages existing data systems to identify aligned opportunities for improvement. Ineffective quality planning includes common missteps such as choosing priorities associated only with benchmarking organizations, continuing improvement projects

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after the desired outcome is achieved (i.e., in control), and focusing on local changes when the data show that system-level change is needed.

Robust and successful quality planning requires the following:

- *Active participation* by executive leadership, key clinical champions, and quality and safety improvement leaders. As one CEO shared with us, the goal is to get everyone engaged so they are committed and accountable.

- *Quantitative and qualitative data* are core to quality planning efforts. Display quantitative data in statistical process control charts to enable identification and appropriate response to variation in process and outcomes data. Depending on familiarity with quality improvement and how to identify normal versus special cause variation, a quick review session may be necessary.

- *Leverage existing knowledge and work quickly* with those directly involved in the systems

and processes. The quality planning leaders will ask staff, "What matters to you?" These staff members know what is broken and will generate effective ideas for improvement. Often, what isn't working is subtle cultural or process issues that have sizeable impact.

- *Be aware of accreditation and benchmarking needs*, but do not let them be the sole drivers of the quality planning process. Too often, health systems cite top-decile performance in common benchmarking

Learning From One Health System's Experience

Colleagues at Children's Healthcare of Atlanta experienced lessons learned in preparing for and executing a quality planning process.

- *Defining the ambition for quality and safety*. With this work forming the foundation of Children's mission, a multidisciplinary team revised and reinvigorated the quality planning framework with an explicit focus on patient and employee safety, flow and capacity management, clinical outcomes, patient and family experience, health and healthcare equity, and accreditation.

- *Listening to and developing solutions with the team*. Executive team presence was critical. Listening to the frank and open discussion on each topic revealed perceived and real barriers to quality, safety and improvement and provided an opportunity for the executive leaders to consider system-level opportunities to help close the gaps.

- *Gaining a broader view of problems and potential solutions*. As Children's prepared for quality planning, it realized the importance of looking at each opportunity more holistically and created a revised template that incorporated the aim, associated measures (in statistical process control charts), and available benchmarks linked with an overlay of the improvement work underway. This template made prioritization more tractable for the quality planning team. The inability to obtain key information was eye opening and instructive.

- *Developing stronger prioritization*. Through the quality planning process, Children's developed a more robust prioritization categorization for its work: system improvement priority, local improvement priority, quality assurance/control and topics requiring analysis to better understand baseline performance. Although seemingly simple, this categorization effectively helped reduce the number of improvement priorities and made clearer the resources required for each effort.

- *Talking about variation is not special cause anymore*. The quality planning effort reinforced the benefits of looking at data over time. Following the quality planning process, executives as well as HR, legal and quality departments are all looking at data over time for key measures. Colleagues speak about common and special cause routinely when reviewing the data.

- *Shifting to a learning and testing culture*. Children's quality planning experience was fast, imperfect and yielded profound successes. The organization has become more comfortable with testing and learning and not trying to design and implement the perfect solution. This has led to increased engagement in improvement work.

services as their priority organizational goal. Though these benchmarks can serve as useful guides, they do not represent wholly local priorities and may be too ambitious or not ambitious enough.

- ***Create a baseline inventory of existing improvement work*** by gathering the high-level aims, progress and strategic alignment of currently allocated improvement resources. If too many projects are underway, quality planning is a great opportunity to winnow down the efforts not aligned with strategic priorities.

- ***Apply an equity lens*** by stratifying key data by race and ethnicity. Even if the process or outcome is "in control" in the aggregate, unstratified data can hide inequities that need urgent attention.

- ***Generate will and energy for a limited number of improvement areas***, generally six to eight. Each opportunity for improvement should be presented in a standardized way that describes the opportunity, the potential impact and an initial theory of change. Use a multivoting process to assign a priority level to each opportunity, which will create a manageable list.

Though an effective quality planning process has specific attributes, one lesson IHI has learned from experience with supporting numerous quality planning process efforts is don't let perfect be the enemy of good. There is great learning in every quality planning process, which helps organizations gain skill and confidence. ▲

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Editor's note: Learn more in the IHI white paper *Whole System Quality* at ihi.org/WholeSystemQuality.

The Importance of Staff Appreciation

Employees feel respected when encouraged to participate and engage.

Darrell K. Terry Sr.,
FACHE, FHELA

Newark Beth Israel Medical Center and Children's Hospital of New Jersey (located in Newark, N.J.) is a 665-bed regional teaching hospital, with more than 3,500 employees and a medical staff of more than 1,000 members. Senior leaders invest a significant amount of time and energy creating opportunities to keep everyone connected to the organization's mission of delivering excellent patient care and supporting our community; finding new ways to support staff is vital. Near the end of 2022, the organization's turnover rate was 3.58%, down from 28% in 2021.

Rewards, Awards and Recognition
In 2017, Newark Beth Israel Medical Center embarked on a journey toward becoming a high-reliability organization. Staff received training in safety behaviors, while learning both a new safety language and how to use reporting to decrease preventable harm. The staff's hard work paid off, and the organization experienced an 80% reduction in serious safety events.

Today, Newark Beth Israel Medical Center is nationally recognized as a leader in patient safety, with accolades from *Newsweek* ("World's Best Hospital" four times in a row) *Money* magazine ("Best Maternity Hospital") and the Leapfrog Group (several "A" ratings).

To show appreciation for their hard work and dedication to safety, the workforce receives various rewards and recognitions to maintain engagement around safety practices. One example is the "Good Catch" program, where employees receive a trophy for detecting errors or speaking up for safety. A new winner is named every week, and members of the senior leadership team deliver the trophy in person. Many staff members are also active participants in the national Daisy Foundation award program for nurses and the Bee Awards for those who support patient care.

Listen and Act
The organization recently introduced a new series of breakfast sessions in which nursing staff meet with senior leaders to share their concerns. Like so many other hospitals and health systems, Newark Beth Israel Medical Center grapples with the great resignation and employment shifts that are having a destabilizing effect.

These breakfast sessions help raise awareness among nurses about how senior leadership is addressing concerns around staffing, supplies and equipment. Earlier this year, RWJBarnabas Health, a healthcare system to Newark Beth Israel Medical Center, made a significant investment in employee compensation to be competitive in the market. In addition, the medical center has greatly improved nursing ratios, allowing nurses more time at the bedside to focus on patient experience and safety.

Breakfast sessions help raise awareness among nurses about how senior leadership is addressing concerns around staffing, supplies and equipment.

Special Events
Creating special events to recognize individual achievements and collective teamwork is a great way to foster employee engagement. Newark Beth Israel Medical Center conducts several events:

- An annual employee barbecue, service awards and a holiday party for staff and their families.

- A special COVID-19 vaccine clinic appreciation night for employees and volunteers who operated the vaccine clinic and delivered more than 30,000 doses of vaccine to the community.

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- A special food truck festival, thanking staff for achieving outstanding results on the organization's Triennial Joint Commission Survey.

- National Nurses Week and Doctors' Day are celebrated with elaborate ceremonies and external marketing campaigns. At the same time, Newark Beth Israel recognizes ancillary staff, such as environmental services, security, transport and dietary, because everyone is important to the success of the hospital and to the delivery of excellent patient care and experience.

- A contest in which staff picked the name of the $150 million expansion project for a 17,000 square-foot lobby, expanded ED, added ORs, and new critical care and geriatric units. The winning name: Newark Strong.
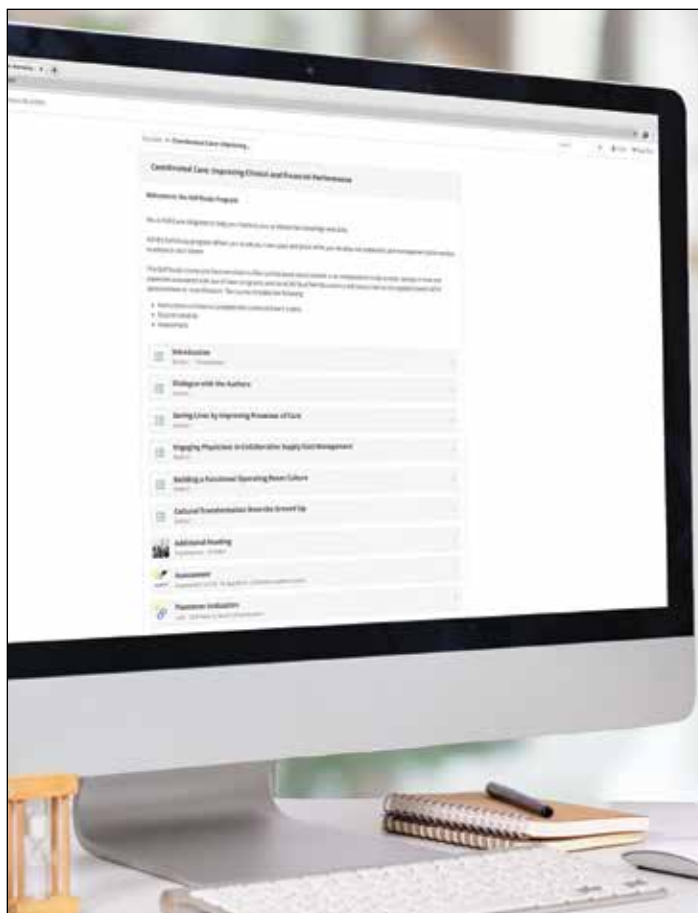
Empathy and Compassion

Newark Beth Israel is a member hospital of the Schwartz Center for Compassionate Healthcare and hosts the Schwartz Center Rounds. The rounds are regularly scheduled meetings that foster discussions among healthcare professionals about the social and emotional issues they face in caring for patients and families.

The sessions bring together clinical and nonclinical staff to discuss a wide range of topics, from the impact of gun violence, to recovering from the COVID-19 pandemic, to the importance of laughter at work. They also provide great insight into how employees are impacted by their work, as well as societal pressures. And they facilitate greater connections between employees across disciplines and departments.

The sessions are also an extension of the organization's commitment to delivering compassionate care. Since its inception in 2003, Newark Beth Israel Medical Center has participated in the Healthcare Foundation of New Jersey Lester Z. Lieberman Humanism in Health Awards. The nomination process gives everyone an opportunity to reflect on how care is delivered and to recognize

those who go above and beyond to connect with patients.

Diversity, Equity and Inclusion
Newark Beth Israel takes great pride in celebrating its diversity. Throughout the year, the Office of Diversity, Equity and Inclusion supports staff in planning numerous cultural celebrations to acknowledge Black History Month, Hispanic Heritage Month, Diwali, Holi, Lunar New Year, Asian Pacific Heritage Month, and PRIDE Month, to name a few. In 2021, Newark Beth Israel became one of the first hospitals in New Jersey to celebrate Juneteenth (June 19) as an official holiday.

In 2021, Newark Beth Israel also named its first chief equity officer, a position dedicated to overseeing the development and implementation of employee and community initiatives that foster equity. When making decisions that impact patients and the overall operations of the hospital, the organization uses a race equity assessment tool to measure the impact on equity, disparities and the community. In addition, the board of trustees formed a DEI subcommittee to ensure diversity on the board.

Employees are also encouraged to share their talents and hobbies. Physicians, nurses and members of the executive team participate in the medical center's annual employee art and photography show. In fact, this year's show was featured in the Newark Arts Festival.

Employees give so much of their time to the hospital, but they bring more to the workplace than the skills they learned in the classroom; they bring their languages, religious practices, foods, customs, traditions and beliefs. It only makes sense for us to embrace these identities and learn more about them and how they shape our institution. Employees also feel appreciated and respected when leaders encourage them to participate and engage with the organization on a variety of levels. ▲

Darrell K. Terry Sr., FACHE, FHELA, is president/CEO, Newark Beth Israel Medical Center and Children's Hospital of New Jersey.

Interim Regents Appointed

Miliner   Schell

Mona E. Miliner, FACHE, vice president, operations, Penn State Health, Hershey, Pa., has been appointed Interim Regent for Pennsylvania.

Nicole L. Schell, FACHE, senior human resources director, UCHealth, Colorado Springs, Colo., has been appointed Interim Regent for Colorado.

ACHE Announces Nominating Committee 2023 Slate

The ACHE Nominating Committee has selected a slate of leaders to be presented for approval at the Council of Regents Meeting, March 18. All nominees have been notified and have agreed to serve if elected. All terms begin at the close of the Council meeting in March. The nominees for the 2023 slate are as follows:

Nominating Committee Member, District 2 (two-year term ending in 2025)
Ashley R. Vertuno, FACHE
CEO
HCA Florida JFK North Hospital
West Palm Beach, Fla.

Nominating Committee Member, District 3 (two-year term ending in 2025)
Mark Schulte, FACHE
Vice President, Operations

Monument Health Rapid City Hospital
Rapid City, S.D.

Nominating Committee Member, District 6 (two-year term ending in 2025)
CAPT Robert T. McMahon III, FACHE
Director, Navy Casualty
Navy Personnel Command

Governor (three-year term ending in 2026)
Thomas B. Lanni Jr., FACHE
President
Beaumont Hospital, Grosse Pointe and Troy
Troy, Mich.

Governor (three-year term ending in 2026)
Karin Larson-Pollock, MD, FACHE
Chief Quality Officer
Providence–Puget Sound Region
Everett, Wash.

Governor (three-year term ending in 2026)
Frances C. Roesch, FACHE
Director, Administration/Obstetrics
 & Gynecology Department
McMaster University/Faculty of Health Sciences
Hamilton, Ontario

Governor (three-year term ending in 2026)
Solomon A. Torres, FACHE
Deputy Executive Director/COO
Brookdale University Hospital
 Medical Center
New York City

Chair-Elect
William P. Santulli, FACHE
COO

Advocate Aurora Health
Downers Grove, Ill.

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

Additional nominations for the offices of Chair-Elect and Governor may be made in the following manner: Any Fellow may be nominated by written petition of at least 15 members of the Council of Regents. Petitions must be received in the ACHE headquarters office (American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698) at least 60 days prior to the annual meeting of the Council of Regents. Regents shall be notified in writing of nominations at least 30 days prior to the annual meeting of the Council of Regents.

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

Michael J. Fosina, FACHE
Carrie Owen Plietz, FACHE
Jennifer D. Alderfer, FACHE
Todd A. Caliva, FACHE
Col Stephanie S. Ku, FACHE
John M. Snyder, FACHE
Jhaymee Tynan, FACHE
Christine C. Winn, FACHE

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ACHE Call for Nominations for the 2024 Slate

ACHE's 2023–2024 Nominating Committee is calling for applications for service beginning in 2024. ACHE Fellows are eligible for the Chair-Elect and Governor vacancies and are eligible for the Nominating Committee vacancies within their districts. Those interested in pursuing applications should review the candidate guidelines for the competencies and qualifications required for these important roles. Open positions on the slate include:

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

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

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

- Four Governors (three-year terms ending in 2027).

- Chair-Elect.

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

- **District 1**: Canada, Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

- **District 4**: Alabama, Arkansas, Kansas, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee, Texas.

- **District 5**: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming.

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

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

Applications to serve and self-nominations must be submitted electronically to krock@ache.org and must be received by July 28. All correspondence should be addressed to Carrie Owen Plietz, FACHE, chair, Nominating Committee, c/o Kim Rock, American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698.

The first meeting of ACHE's 2023–2024 Nominating Committee will be held March 21 during the 2023 Congress on Healthcare Leadership in Chicago. The committee will be in open session at 2:45 p.m. Central time. During the meeting, an orientation session will be conducted for potential candidates, giving them the opportunity to ask questions regarding the nominating process. Immediately following the orientation, an open forum will be provided for ACHE members to present and discuss their views of ACHE leadership needs.

Following the July 28 submission deadline, the committee may meet to determine which candidates for Chair-Elect and Governor will be interviewed. All candidates will be notified of the committee's decision no later than Sept. 29, and candidates for Chair-Elect and Governor will be interviewed in person Oct. 19.

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

Call for Proposals: Management Innovations Poster Session

ACHE invites authors to submit narratives of their posters to be considered for the 38th annual Management Innovations Poster Session scheduled to take place at ACHE's 2023 Congress on Healthcare Leadership, March 20–23. This is a unique opportunity for authors to share their organizations' innovative work with other healthcare leaders. We are interested in innovations addressing issues that might be helpful to others, including improving quality or efficiency, improving patient or physician satisfaction, implementation of EHRs, uses of new technology, and similar topics.

Please visit **ache.org/CongressPosterSession** for the full selection criteria. Narratives should be submitted as an email attachment and sent to PosterSessions@ache.org by Jan. 17.

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

ACHE and the American Hospital Association's Institute for Diversity and Health Equity are pleased to announce that registration is open for the Institute's 2023 Summer Enrichment Program at ifdhe.aha.org/summer-enrichment-program-overview.

The Summer Enrichment Program grows and strengthens the pipeline of healthcare leaders from underrepresented groups and places diverse graduate students pursuing advanced degrees in healthcare administration or a related field in 10-week, paid internships across the country. Starting in October 2022, registration opened for host sites and students interested in participating in these experiences.

ACHE and the Institute are co-promoting the SEP to increase the number of students who participate in the program each year and, accordingly, increase the number of host sites. Just as students benefit from experiential learning, host sites gain the experience of mentoring, educating and collaborating with new and upcoming leaders.

For more information about the SEP or on becoming a host site, visit ifdhe.aha.org/summer-enrichment-program-overview or contact either the Institute at ifd-sep@aha.org or (312) 422-2690 or Anita Halvorsen, FACHE, senior vice president, Executive Engagement, ACHE, at ahalvorsen@ache.org or (312) 424-9370.

ACHE Chapters Recognized for Their Commitment to Diversity

Five chapters received the 2022 Regent-at-Large Award for their accomplishments in diversity. To be eligible to receive an award, a chapter must actively demonstrate commitment to and successful execution of significant diversity and inclusion initiatives within the chapter, community and healthcare management field. The following chapters received the award during the annual Chapter Leaders Conference, which took place Sept. 19–20, 2022, in Chicago. For more on the winners, see "Chapter News" on Page 62.

- **District 1:** Healthcare Leaders of New York.
- **District 2:** ACHE—North Florida Chapter.
- **District 3:** ACHE—MN Chapter.
- **District 4:** South Texas Chapter of the American College of Healthcare Executives.
- **District 5:** Washington Chapter of ACHE.

2022 Executive Program: Helping Leaders Advance

In November, nearly 60 healthcare leaders completed ACHE's 2022 Executive Program, composed of Executive, Senior Executive and Physician Executive cohorts. This virtual three-module series was held over five months, with the first module beginning in July of last year, and the two subsequent modules held in September and November.

ACHE's 2022 Executive Program featured sessions led and facilitated by leading healthcare experts, individualized career coaching, professional leadership assessments and health system site visits that delivered unique insights on topics relevant to the specific challenges that healthcare leaders are facing. The Executive Program supports professional growth and enhances organizational advancement. The participants also benefit from the lasting relationships and shared knowledge that this unique learning experience offers.

The Executive Program will be held in both virtual and in-person formats in 2023. More information will be available soon.

2022 Dolan Scholars Share Their Experiences

The 37 scholars selected for the 2022 Thomas C. Dolan Executive Diversity and Career Accelerator programs completed their work in December. Both programs, each six months in duration, provided this diverse group of healthcare leaders with education, mentoring and networking experiences to prepare them for higher-level positions in hospitals, health systems and other healthcare organizations. The Executive Diversity Program, which had 12 scholars, consisted of e-learning, including live and recorded webinars, self-study materials, and three in-person sessions, while the Career Accelerator Program, with 25 scholars, was exclusively virtual and consisted of 14 virtual live sessions.

The Dolan scholars are empowered through a structured curriculum

and activities that cultivate strong leadership presence; sharpen expertise in diversity, equity and inclusion; build critical thinking skills; and expand one's capacity to navigate career opportunities and challenges. Two of the Executive Diversity Program scholars, **Kristan M. Murray, FACHE**, and **Sonney Sapra**, shared their experiences and how the program helped win their leadership development.

Kristan M. Murray, FACHE, associate director/COO, VA Southern Nevada Healthcare System, North Las Vegas.

Murray

When starting new leadership roles in the past, Kristan M. Murray, FACHE, often faced the incorrect assumption by others that she was hired to increase the diversity of a workplace rather than hired based on her expertise and vast experience in healthcare leadership.

Murray has worked tirelessly to ensure that diversity is valued and exists at all levels of an organization under her purview. At the VA Southern Nevada Healthcare System in North Las Vegas, Murray provides executive oversight of the facility's operations and direction for the administrative and support services that ensure continuity of care for the patients served. She also oversees the Organizational and Veteran Health Council and several facility committees within the council's jurisdiction. Those committees focus on organizational culture with special emphases on employee, patient and community engagement.

Murray also champions causes, the creation of local committees, initiatives and opportunities that promote diversity, equity and inclusion to highlight the importance of appreciating our differences. Equity of voice, while honoring individuals' experiences, allows for the consideration of varying perspectives in the decision-making process.

When Murray learned of her acceptance into the Thomas C. Dolan Executive Diversity Program, she said it was "the most welcomed surprise." Murray also soon learned she was the only scholar selected from the Department of Veterans Affairs, and she feared the other members of her cohort would not relate to her experiences in healthcare. However, she quickly learned during the cohort's first meeting that many of the other scholars faced similar challenges, interpersonally and organizationally, as they worked to improve the patient care their organizations provided.

ACHE's Thomas C. Dolan Executive Diversity Program embraces differences and affords leaders from diverse backgrounds the opportunity to hear from world-class experts, authors and thought leaders, all of whom have helped to reshape her perspective.

The program's teambuilding activities, dinner conversations, opportunities for reflection and educational sessions forged true friendships and collegiality among the cohort members. Not only did the scholars truly enjoy spending time together, they gave Murray grace, i.e., time to share and reflect candidly while providing her with compassionate, affirming feedback. They allowed for frank conversations, pushed her to be a better version of herself and

provided her with a circle of peers to lean on that many executives lack once they reach a certain leadership level. Having access to a group of like-minded individuals with whom you can share and who will provide candid feedback is an integral component of continued development and sustainability.

When Murray applied for the Executive Diversity Program, she hoped to gain tools to help her manage personalities from diverse backgrounds, foster an inclusive environment throughout the organization, and help her identify opportunities for greater diversity in her workplace. As she completed the program, Murray knew wholeheartedly that she could be the change she wants to see.

Sonney Sapra, senior vice president/CIO, information systems, Samaritan Health Services, Corvallis, Ore.

Sapra

For Sonney Sapra, it was an honor to be selected as a 2022 Thomas C. Dolan Executive Diversity Program scholar. It was very clear to Sapra during the first session of the program that ACHE had selected a diverse, highly regarded group of leaders, and that they were going to become close and grow from each other's experiences.

"There is so much value in this program because not only are we learning from leading-edge organizations in healthcare, but we are learning from each other," Sapra says. During the six-month program, he and other members of the cohort expressed a profound sense of having found their community—an experience that was incredibly powerful for Sapra.

Learning about others' experiences and how they were participating in and driving diversity, equity and inclusion initiatives at their own organizations was also very insightful.

Sapra's ultimate career goal is to become a CEO. However, as a CIO, he is taking a more unconventional path to get there since most boards expect CEO candidates to have operational experience, which is typically obtained from being a COO.

In his role as CIO, Sapra is involved in projects and decisions that directly affect many of the clinical departments. Understanding the people and processes of various departments and how technology may impact them and their success has given him a deep understanding of operational workflows. He uses that knowledge to guide those departments with the best solutions. Although he manages many operational issues that touch all parts of the organization, Sapra acknowledges that to become a CEO, he must first hone the operational skills expected of a COO.

The Dolan Executive Diversity Program has given Sapra the opportunity to learn how others in his cohort are dealing with similar issues in the field, such as staffing and high costs. Open discussions and collaboration with the other scholars has helped him to approach these challenges differently and to think about how he can apply some of that knowledge to his own organization.

"I am extremely grateful for ACHE and the opportunity to be part of the 2022 Thomas C. Dolan Executive Diversity Program," he says. "Spending time with this distinguished group of leaders during the last six months has clearly shown me that the future of healthcare is in good hands. Now, it's time for us to take the healthcare field to new heights."

The Executive Diversity Program has offered specialized leadership development for diverse leaders since it was established in 2014 by the Foundation of ACHE's Fund for Healthcare Leadership to honor Thomas C. Dolan, who served as president and CEO of ACHE from 1991 to 2013. The program honors his long-standing service to the profession of healthcare

ACHE IS NOW ACCEPTING
SCHOLARSHIP APPLICATIONS

- **Albert W. Dent Graduate StudentScholarship (for racially and/or ethnically and LGBTQ diverse students)**

- **Foster G. McGaw Graduate Student Scholarship**

Do you know a healthcare management student who needs financial aid? ACHE is currently accepting applications for the Albert W. Dent and Foster G. McGaw graduate student scholarships until **March 31, 2023**.

For more information visit **ache.org/Scholarships**

Applicants will be notified in July.

leadership and furthers his strong commitment to achieving greater diversity among senior healthcare leaders. In 2021, the program was expanded with the addition of the Career Accelerator Program, designed for diverse mid-careerists to support their career advancement. For more information about the Executive Diversity and Career Accelerator programs, visit **ache.org/ExecutiveDiversity**.

Fellow Named to AHA Board
The American Hospital Association elected **Marc L. Boom, MD, FACHE**, president/CEO, Houston Methodist, to a three-year term on its board of trustees beginning Jan. 1.

IHF Announces 2022 Award Winners
ACHE congratulates the recipients of the 2022 International Hospital Federation Awards. These awards, which include the American College of Healthcare Executives Excellence Award for Leadership and Management, are recognized around the world as the premier awards program to honor hospitals and healthcare organizations. IHF announced the 2022 winners Nov. 10 and presented the awards during a special ceremony at the 45th World Hospital Congress in Dubai, United Arab Emirates, Nov. 9–11, 2022.

The ACHE Excellence Award for Leadership and Management recognizes hospitals or health service providers that demonstrate excellence or outstanding achievements in leadership and management in leading a hospital or healthcare organization. The 2022 winners of this award are:

Gold:
- Emirates Health Services, United Arab Emirates, for its Mental Health of Older Adults Clinical Academic Group project.

Silver:
- Emirates Health Services, United Arab Emirates, for its transformation of AMI (acute myocardial infarction), advanced AV (atrioventricular) block and bariatric surgery management through digitalized clinical pathways.
- Tan Tock Seng Hospital, Singapore, for its "Hospitals Without Walls" digital transformation strategy.

Bronze:
- Commonwealth Healthcare Corporation, Northern Mariana Islands, for its Cancer and Associated Risks Early Screening project.
- Pathology and Genetics Department–Dubai Academic Health Corporation, United Arab Emirates, for leading an innovative and sustainable approach in fighting the COVID-19 pandemic for better patient outcomes.
- Emirates Health Services, United Arab Emirates, for its Healthcare Innovation Framework.
- Philippine Children's Medical Center, Philippines, for its "TATAG PCMC," the PCMC hemodialysis unit's COVID-19 pandemic response.

This year, IHF received 400 entries from 35 countries and territories—the highest number of submissions since the awards were established in 2015. To learn more about all of the award winners and finalists, visit worldhospitalcongress.org/2022-winners and worldhospitalcongress.org/ihf-awards-finalists, respectively.

(Cont. from Page 6)

Efforts to advance equity in care are gaining momentum, but still much more is needed. By being intentional about prioritizing DEI in everything we do and who we are as leaders, we can accelerate our progress in ways that matter most for patients.

Stay tuned for the ACHE survey *Comparing Career Attainments of Healthcare Executives by Race/Ethnicity.* Issued every six years, the survey compares the experiences and opinions of leaders of different races and ethnicities and offers data-based recommendations for them to consider as they address racial/ethnic relations in their own organizations. Results from the latest edition will be released soon. ▲

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

In Memoriam

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

John O. Bush Jr., FACHE
Lewisville, Texas

John J. Short, FACHE
Naperville, Ill.

LEADERS IN ACTION

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

Anthony A. Armada, FACHE
Chair
Chicago Health Executives Forum
2022 CHEF October Face-to-Face
 Education Program and ACHE
 Update
Chicago
(October 2022)

ACHE of Southern California
2022 Annual Conference
Long Beach, Calif.
(December 2022)

Delvecchio S. Finley, FACHE
Chair-Elect
The Connecticut Association of
 Healthcare Executives
Healthcare Beyond the Horizon
Uncasville, Conn.
(November 2022)

Carrie Owen Plietz, FACHE
Immediate Past Chair
Nevada Chapter of the American
 College of Healthcare Executives
Nevada Healthcare Forum
Las Vegas
(October 2022)

William P. Santulli, FACHE
Governor
Northern New England Association
 of Healthcare Executives
2022 Annual Meeting
Portland, Maine
(November 2022)

Michele K. Sutton, FACHE
Governor
West Virginia Hospital Association
 and the West Virginia State Medical
 Association
Health Care Leadership Summit
White Sulfur Springs, W.Va.
(November 2022)

ACHE STAFF NEWS

ACHE Staff Members Receive Service Awards
The following ACHE staff members recently received awards for service anniversaries.

20-Year Service Award
Sheila T. Brown, chapter relations specialist, Chapter Relations, Department of Executive Engagement.

15-Year Service Award
John M. Buell, managing editor, *Healthcare Executive*, Department of Communications and Marketing.

Caitlin E. Stine, content marketing specialist, Department of Communications and Marketing.

10-Year Service Award
Sonia S. Hernandez, governance coordinator, Executive Office.

Five-Year Service Award
Cristina Cuevas, senior customer service representative, Customer Service Center, Department of Executive Engagement.

Shannon E. Heflin, coordinator, Development, Executive Office.

Ericka P. Taylor, lead trainer, Customer Service Center, Department of Executive Engagement.

ACHE Announces New Hires, a Promotion and a Title Change
Following are new hire, promotion and title change announcements.

Patty M. Adducci welcomed as executive assistant to the president/CEO, Executive Office.

Stephanie M. Del Toro welcomed as partnerships specialist, Department of Learning.

Tom Halkar welcomed as web developer, Department of Information Technology.

Mary F. Howorth promoted to education specialist, Professional Development, Department of Learning, from events coordinator.

Sandra McGarry's title was changed to chapter education specialist, Professional Development, Department of Learning, from learning specialist.

LEADERSHIP opportunities outside of your current position

NETWORKING events with peers and mentors within your community

EDUCATION opportunities that are close to home and can come to you

LEADERSHIP

NETWORKING

EDUCATION

YOU

IMAGINE THE POSSIBILITIES

WHEREVER YOU ARE, YOUR CHAPTER IS THERE.

ACHE.ORG/CHAPTERS

American College of Healthcare Executives
for leaders who care®

Adkins

Caine

Holt

Kernizan

Kirton

Rux

Deno Adkins, FACHE, to senior vice president, Ambulatory and Consumer Services, Cone Health, Greensboro, N.C., from vice president, Ambulatory Network.

Robert W. Allen, FACHE, to president/CEO, Intermountain Healthcare, Salt Lake City, from senior vice president/COO.

Natalie A. Caine, FACHE, to chief administrative officer, Mayo Clinic, Rochester, Minn., from associate administrator, Department of Medicine.

D. Montez Carter, PharmD, FACHE, to president/CEO, Trinity Health of New England, Hartford, Conn., from president/CEO, St. Mary's Health Care System, Athens, Ga.

Thomas (Tim) E. Feldman to CEO, Mind Genomics Advisors Inc., Saratoga Springs, N.Y., from vice president/general manager, Healthcare Compliance, Wolters Kluwer, Philadelphia.

Dominic Giroux, FACHE, to chair, Ontario Hospital Association board of directors. Giroux is also the president/CEO of Health Sciences North and Health Sciences North Research Institute, Sudbury, Ontario.

David L. Holt, FACHE, to medical center director, VA Portland (Ore.) Health Care System, from medical center director, VA White City, Ore.

Lorna M. Kernizan, FACHE, to COO, Children's of Mississippi, Jackson, Miss., from COO, Palms West Hospital, West Palm Beach, Fla.

Carl A. Kirton, DNP, RN, ANP, to editor-in-chief, *American Journal of Nursing*, Philadelphia, from CNO, University Hospital, Newark, N.J.

Gail W. Kosyla, CPA, FACHE, to CFO, Yale New Haven (Conn.) Health from executive vice president, System Financial Operations, RWJBarnabas Health, West Orange, N.J.

Adrienne M. Olson, DNP, RN, FACHE, to CNO/vice president, Patient Care Services, Bryan Medical Center, Lincoln, Neb., from CNO/clinical services manager, Kearney (Neb.) Regional Medical Center.

Mark Parrington, FACHE, to retirement from system senior vice president, Mergers and Acquisitions, CommonSpirit Health, Englewood, Colo. We would like to thank Mark for his many years of service to the healthcare field.

Steven J. Price to partner, Life Sciences & Healthcare Practice,

Caldwell Partners, Toronto, from divisional vice president, Merritt Hawkins/AMN Healthcare, Dallas.

Susan Rux, PhD, RN, FACHE, to director, Professional Development and Practice Innovation, Fox Chase Cancer Center, Philadelphia, from Alliance Dean of Academic Affairs, Chamberlain University, North Brunswick, N.J.

Michael L. Stern, FACHE, to COO, Tower Health, West Reading, Pa., from executive vice president/COO, Hospital Division, MetroHealth System, Cleveland.

Carlyle L. Walton, FACHE, to CEO, Phoebe Sumter Medical Center, Americus, Ga., from president, Adventist Health Policy Association, Washington, D.C.

Lindsley A. Withey, FACHE, to managing director, BDC Advisors LLC, Miami, from director/facility planning solution leader, Health, Guidehouse, Chicago.

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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 leadership.

Aemal Aminy, FACHE, director, security, Alameda Health System, Oakland, Calif., received the Early Career Healthcare Executive Award from the Regent for California–Northern & Central.

Sheila Baxter, director, business development, Kaiser Permanente, Oakland, Calif., received the Early Career Healthcare Executive Award from the Regent for California–Northern & Central.

Teri L. Bergeleen, FACHE, director, Provider Contracting/ACO Operations, Avera Health, Sioux Falls, S.D., received the Early Career Healthcare Executive Award from the Regent for South Dakota.

Charles D. Callahan, PhD, FACHE, president, Memorial Hospital Group, Memorial Health, Springfield, Ill., received the Senior-Level Healthcare Executive Award from the Regent for Illinois–Central & Southern.

Debra A. Flores, RN, FACHE, senior vice president/manager, Greater Southern Alameda Area, Kaiser Permanente, Oakland, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California–Northern & Central.

Austin M. Gillard, FACHE, CEO, Clay County Medical Center, Clay Center, Kan., received the Senior-Level Healthcare Executive Award from the Regent for Kansas.

Allison Goldasich, project manager, Memorial Health, Springfield, Ill., received the Early Career Healthcare Executive Award from the Regent for Illinois–Central & Southern.

James D. Grant, MD, FASA, senior vice president/CMO, Blue Cross Blue Shield of Michigan, Detroit, received the 2021 Distinguished Service Award from the American Society of Anesthesiologists. The award is the highest honor ASA bestows and is presented annually to a member who has transformed the specialty of anesthesiology.

Rebecca Hunter, FACHE, vice president, Planning & Service Lines, HCA Healthcare (Mountain Division), Salt Lake City, received the Senior-Level Healthcare Executive Award from the Regent for Utah.

Terry E. Moss, COO, Ivinson Memorial Hospital, Laramie, Wyo., received the Early Career Healthcare Executive Award from the Regent for Wyoming.

Siri T. Nelson, FACHE, CEO, Marshall Medical Center, Placerville, Calif., received the Senior-Level Healthcare Executive Award from the Regent for California–Northern & Central.

Kyle Richards, FACHE, executive director, Good Samaritan St. Martin Village, Rapid City, S.D., received the Senior-Level Healthcare Executive Award from the Regent for South Dakota.

Nikhil Singal, FACHE, vice president, Operations, Sierra Health & Wellness Centers, Sacramento, Calif., received the Early Career Healthcare Executive Award from the Regent for California–Northern & Central.

Janet Stanek, FACHE, secretary, Kansas Department of Health & Environment, Topeka, Kan., received the Exceptional Achievement and Service Award from the Regent for Kansas.

Timothy N. Thornell, FACHE, president/CEO, Cheyenne (Wyo.) Regional Medical Center, received the Senior-Level Healthcare Executive Award from the Regent for Utah.

Kali Wall, Primary Children's Hospital, Salt Lake City, received the Early Career Healthcare Executive Award from the Regent for Utah.

Thomas Whelan, FACHE, CEO, Cibola General Hospital, Grants, N.M., received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Advancing Diversity and Inclusion

Chapters are recognized for their commitment.

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

Each year, Regents-at-Large recognize chapters that actively demonstrate a commitment to and successful implementation of significant diversity, equity and inclusion efforts within the chapter, community and healthcare management field.

Anthony A. Armada, FACHE, Chair, American College of Healthcare Executives, presented the awards and congratulated the winners during the conference's opening session, thanking all chapters for their work fostering engagement in diversity and inclusion. The following chapters received the 2022 Regent-at-Large Awards, which were given during ACHE's annual Chapter Leaders Conference in September.

Healthcare Leaders of New York

Healthcare Leaders of New York was honored in two ways: for its own work in recognizing a healthcare organization or institution for its DEI efforts, and for the chapter's continued focus on delivering quality education to its members.

Each year Healthcare Leaders of New York honors a healthcare organization or institution of higher learning that has taken the American Hospital Association and the Institute for Diversity and Health Equity's #123forEquity pledge; is making major strides in developing, training and hiring diverse healthcare leaders; and is implementing and executing diversity initiatives and programs.

Columbia University Irving Medical Center was awarded for its exemplary performance and implementation of programs focused on the elimination of health disparities, raising culture competence among healthcare leaders to ensure culturally responsive care and strengthening partnerships in the communities they serve.

Also annually, the chapter hosts a diversity-focused panel discussion. In 2022, the topic was "Cultivating an Inclusive Organization to Retain Diverse Talent." The chapter hosted a networking event in collaboration with National Association of Health Services Executives and the National Association of Latino Healthcare Executives. In 2021, the virtual panel event was titled "What's in your Toolbox: How Executives Create One to Address Equity, Diversity, Access and Build Trust in Healthcare."

Healthcare Leaders of New York continue to make strides and expand access to diverse programs, educate, train and collaborate with diverse healthcare leaders, while leading initiatives that address the community's needs.

ACHE—North Florida Chapter

By forming alliances and partnerships with the National Association of Health Services Executives, the Florida Hospital Association and other state healthcare organizations, the ACHE—North Florida Chapter was honored for actively demonstrating a commitment to and successful execution of significant diversity and inclusion efforts. This, despite the challenges of leading the largest geographical ACHE chapter in Florida.

The alliances and engagement with its leadership has enabled ACHE—North Florida Chapter to create a best-practice environment with the other ACHE chapters in Florida, which resulted in the first statewide DEI event. The event furthered the discussion and laid a foundation for other organizations to follow.

The chapter, in partnership with NAHSE Florida, co-hosted an in-person career positioning event and dinner, enabling students and early careerists to be exposed to networking and career opportunities. The program had the chapter's highest in-person attendance, with more than 150 members and potential members. It is this kind of intentionality around DEI that demonstrates ACHE—North Florida Chapter's commitment to this area.

ACHE—MN Chapter

ACHE—MN Chapter was honored for its commitment to DEI, reflected in many of its recent activities and initiatives, including the following: Incorporated perspectives in education programs from diverse leaders and

organizations that serve diverse communities.

Formed alliances to support DEI such as partnering with the National Association of Health Services Executives Heartland Better Together Collaborative in Nebraska to increase and sustain diversity in healthcare leadership through quality educational programming, co-sponsorship and allyship.

Partnered with academic programs to support the development of emerging, diverse leaders who are representative of Minnesota's rich diversity. ACHE—MN Chapter worked with The University of Minnesota School of Public Health Healthcare Leadership Symposium, which featured a session titled "Promoting Health Equity as a Strategic Priority."

Strengthened its membership and mentoring to advance diversity. For example, an intentionally selected team of three board members and two early careerists received scholarships to attend a two-day training on strategic planning. Participants applied their learnings by facilitating the chapter's strategic planning process. The early careerists continued to engage with the chapter by joining the Finance and Communications committees.

South Texas Chapter of the American College of Healthcare Executives
The South Texas Chapter of the American College of Healthcare Executives was honored for its strong diversity and inclusion efforts this past year.

The chapter hosted a DEI-focused in-person education session this past summer that had two panel discussions: "Fostering Inclusion of LGBTQ

Patients and the Healthcare Workforce," and "Understanding Implicit Bias and its Impact on Healthcare Leadership." It also updated and approved a new chapter diversity statement, which included chapter diversity goals for 2022.

In addition, the DEI Committee partnered with the San Antonio Metropolitan Health District to host health training for clinicians and administrators on health equity. Also, board members presented a session on a creating a safe classroom environment to express, discuss and debate DEI and social justice issues at the Association of University Programs in Health Administration Annual Conference in June.

These initiatives continue to support ACHE's commitment to diversity and inclusion and are well-recognized by its members and other organizational stakeholders. Collaboration has already started with the Central Texas Chapter—ACHE to help support similar programming and educational events.

Washington Chapter of ACHE
This year, Washington Chapter of ACHE's Diversity, Equity and Inclusion Committee made significant strides in their work to engage diverse individuals.

For example, the committee implemented quarterly "Meet and Mingle" events focused on DEI topics. The DEI committee has also created a "Discussion Agreement" that has been incorporated as a standard reflection at the beginning of every chapter event and meeting:

Tension and Conflict = Opportunities for Growth and Expansion

1. Be present
2. Listen and respect
3. Honor confidentiality
4. Trust intent
5. Acknowledge impact
6. Embrace imperfection
7. Expect and accept non-closure
8. THERE IS NO QUICK FIX

Also, the committee created a chapter annual award to honor individuals and organizations who embody and promote DEI. Criteria for the award included promoting an equitable environment of care for the communities they serve; engaging in efforts to create a welcoming environment for all or improve inclusion within their workspace or community; and serving as a role model for others by empowering those around them through DEI activities and professional advancement.

Additionally, a new affinity group, the Women's Healthcare Executive Network, holds monthly meetings with female healthcare leaders in Washington who are interested in creating a diverse and supportive culture to foster networking and leadership. This group has one of the largest participation numbers of all its affinity groups. More affinity groups are in development, including one for LGBTQ healthcare leaders.

This committee is one of the most active areas in the chapter and it has made tremendous strides this past year in engaging the membership. ▲

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

Code of Ethics

As amended by the Board of Governors on Dec. 6, 2021.

Preamble

The purpose of the *Code of Ethics* of the American College of Healthcare Executives is to serve as a standard of conduct for members. It contains standards of ethical behavior for healthcare executives in their professional relationships. These relationships include colleagues, patients or others served; members of the healthcare executive's organization and other organizations; the community; and society as a whole.

The *Code of Ethics* also incorporates standards of ethical behavior governing individual behavior, particularly when that conduct directly relates to the role and identity of the healthcare executive.

The fundamental objectives of the healthcare leadership profession are to maintain or enhance the overall quality of life, dignity and well-being of every individual needing healthcare service and to create an equitable, accessible, effective, safe and efficient healthcare system.

Healthcare executives have an obligation to act in ways that will merit the trust, confidence and respect of healthcare professionals and the general public. Therefore, healthcare executives should lead lives that embody an exemplary system of values and ethics.

In fulfilling their commitments and obligations to patients or others served, healthcare executives function as moral advocates and models. Since every leadership decision affects the health and well-being of both individuals and communities, healthcare executives must carefully evaluate the possible outcomes of their decisions. In organizations that deliver health services, they must work to safeguard and foster the rights, interests and prerogatives of patients or others served.

The role of moral advocate requires that healthcare executives take actions necessary to promote such rights, interests and prerogatives.

Being a model means that decisions and actions will reflect personal integrity and ethical leadership that others will seek to emulate.

I. The Healthcare Executive's Responsibilities to the Profession of Healthcare Leadership

The healthcare executive shall:

A. Uphold the *Code of Ethics* and mission and values of the American College of Healthcare Executives;

B. Conduct professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon the profession;

C. Comply with all laws and regulations pertaining to healthcare leadership in the jurisdictions in which the healthcare executive is located or conducts professional activities;

D. Maintain competence and proficiency in healthcare leadership by implementing a personal program of assessment and continuing professional education;

E. Avoid the improper exploitation of professional relationships for personal gain;

F. Disclose—and when required or determined by a board review of the executives' disclosure, avoid—financial and other conflicts of interest;

G. Use this *Code* to further the interests of the profession and not for self-serving reasons;

H. Respect professional confidences;

I. Enhance the dignity and image of the healthcare leadership profession through positive public information programs; and

J. Refrain from participating in any activity that demeans the credibility and dignity of the healthcare leadership profession.

II. The Healthcare Executive's Responsibilities to Patients or Others Served

The healthcare executive shall, within the scope of his or her authority:

A. Work to ensure the existence of a culture of respect and dignity;

B. Build trust with all patients;

C. Work to ensure the existence of a process to evaluate the safety, quality and equity of care or service rendered;

D. Work to ensure fair and equitable processes pertaining to patients' financial matters;

E. Work to ensure that safeguards exist that will not allow discriminatory organizational practices to exist;

F. Work to ensure the existence of a process that will advise patients or others served clearly and truthfully of the rights, opportunities, responsibilities and risks regarding available health services;

G. Work to ensure that there is a process in place to facilitate the resolution of conflicts that may arise when the values of patients and their families differ from those of employees and physicians;

H. Demonstrate zero tolerance for any abuse of power that compromises patients or others served;

I. Work to provide a process that ensures the autonomy and self-determination of patients or others served;

J. Work to ensure the existence of procedures that will safeguard the confidentiality and privacy of patients or others served; and

K. Work to ensure the existence of an ongoing process and procedures to review, develop and consistently implement evidence-based clinical practices throughout the organization.

III. The Healthcare Executive's Responsibilities to the Organization

The healthcare executive shall, within the scope of his or her authority:

A. Lead the organization in prioritizing patient care above other considerations;

B. Provide health services consistent with available resources, and when there are limited resources, work to ensure the existence of a resource-allocation process that reflects the ethical considerations of fairness and equity;

C. Conduct both competitive and cooperative activities in ways that improve community health services;

D. Lead the organization in the use and improvement of standards of management, leadership and sound business practices;

E. Respect the customs, beliefs and practices of patients or others served, consistent with the organization's philosophy;

F. Be truthful in all forms of professional and organizational communication, and do not disseminate information that is false, misleading or deceptive;

G. Report negative financial and other information promptly and accurately, and initiate appropriate action;

H. Prevent fraud and abuse and aggressive accounting practices that may result in disputable financial reports;

I. Create an organizational environment in which both clinical and leadership mistakes are minimized and, when they do occur, are disclosed and addressed effectively;

J. Work to ensure the organization complies with all applicable laws and regulations;

Code of Ethics

(Cont.)

K. Work with local, regional, statewide and federal organizations to ensure adequate response to identified public health emergencies. (This should include appropriate pre-planning and exercises of such plans.)

L. Implement an organizational code of ethics, including conflict of interest principles and whistleblower protections, and monitor compliance; and

M. Provide ethics resources and mechanisms for staff to address organizational and clinical ethics issues.

IV. The Healthcare Executive's Responsibilities to Employees

Healthcare executives have ethical and professional obligations to the employees they manage that encompass but are not limited to:

A. Creating a work environment that promotes ethical and equitable conduct;

B. Providing a work environment that encourages a free expression of ethical concerns and provides mechanisms for discussing and addressing such concerns;

C. Promoting a healthy work environment, which includes freedom from harassment, sexual and other, and coercion of any kind, especially to perform illegal or unethical acts;

D. Promoting a culture of inclusivity that seeks to prevent discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, age or disability;

E. Work to ensure that there is a process in place to facilitate the resolution of conflicts that may arise between workforce members or the individual and the organization;

F. Providing a work environment that promotes the proper use of employees' knowledge and skills;

G. Providing a safe, healthy and equitable work environment; and

H. Promoting a culture in which employees are provided fair compensation and benefits based upon the work they perform.

V. The Healthcare Executive's Responsibilities to Community and Society
The healthcare executive shall:

A. Work to identify, and in partnership with other organizations in the community, meet the health needs of the community;

B. Work to identify and seek opportunities to foster health promotion in the community;

C. Work to support access to health services for all people;

D. Encourage and participate in public dialogue on healthcare policy issues, and advocate solutions that will improve the health status of the community and access to care and will promote quality healthcare;

E. Apply short- and long-term assessments to leadership decisions affecting both community and society;

F. Provide prospective patients and others with adequate and accurate information, enabling them to make enlightened decisions regarding services; and

G. Work to support access to healthcare services to all people, particularly the underserved and disenfranchised.

VI. The Healthcare Executive's Responsibility to Report Violations of the *Code*
A member of ACHE who has reasonable grounds to believe that another member has violated this *Code* has a duty to communicate such facts to the ACHE Ethics Committee.

ACHE Recognition Program
SHOW YOUR STARS

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

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★★ Distinguished Service Award = 75 points

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American College *of* Healthcare Executives
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LEADERSHIP

Quiet Quitting: What Leaders Can Do About It

It seems one can't meet with family, friends or colleagues; go on social media; or read a newspaper or business magazine without coming across the ubiquitous idiom "quiet quitting."

Quiet Quitting Defined

Quiet quitting is typically defined as an employee who does exactly what is required without contributing more or trying to advance their career. It isn't a movement to be lazy as much as it is a movement to reach a healthy work-life balance. There is no volunteering for additional projects or work-community activities. Employees who are "quiet quitting" don't participate in any outside work-sponsored events, nor do they step in when someone is struggling with a project or needs help organizing one of the events. Quiet quitters do the bare minimum, check out and go home.

What Can Leaders Do?

Though employees are quiet quitting for a variety of reasons, there are four steps leaders can take to alleviate the situation.

1. *Keep employees engaged*. Engagement begins with employees feeling that they are doing meaningful work. Without meaningful work, it's just a job. Leaders are advised to provide careful listening and advocacy, set and maintain realistic expectations, monitor engagement, recognize and reward accomplishments, and create a psychologically safe culture.

2. *Take time to understand what isn't working*. Encourage your employees to be clear and transparent in their communication as you model the same. Set healthy work boundaries and help your team members prioritize—especially your newer, younger employees. Connect with those you lead on an appropriate and authentic level.

3. *Hold one-on-one conversations*. They are the perfect environment to help younger employees break down larger projects into bite-sized tasks that do not overwhelm them. Honor their time away from the office by putting email on send delays and connecting with them only during business hours.

4. *Encourage efficiencies*. Allow everyone to lean into less by finding ways to focus on efficiency and the elimination of unnecessary tasks. Be cautious that quiet quitting may not stem from work stress alone. Encourage employees to create healthy boundaries to preserve their home life.

By creating an environment in which employees can pursue work that is meaningful to them, while at the same time protecting them from task overload in a fear-based culture, employees can find a more productive and fulfilling alternative to quiet quitting.
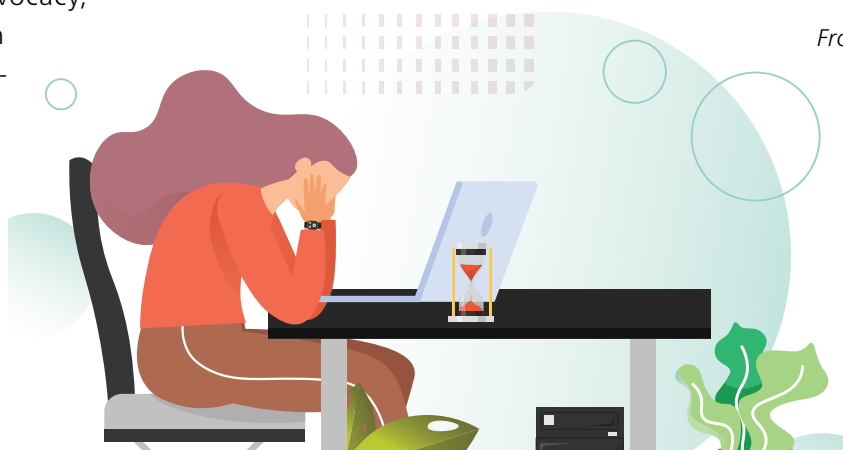
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