

HEALTHCARE EXECUTIVE

The Magazine for
Healthcare Leaders

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CEO Focus: Engaging
and Aligning Leaders

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Cover Story

18 **Necessary Change: Redesigning Care to Achieve Patient Safety**



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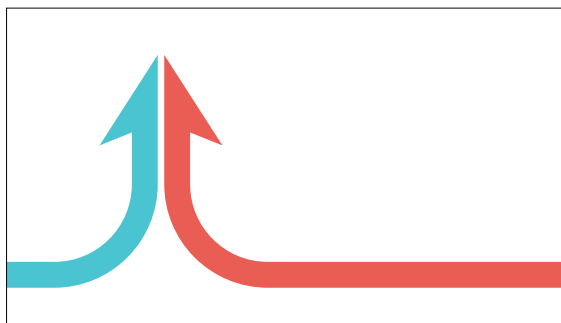
Care redesign efforts that are underway to improve patient safety and quality should continue, despite epidemic levels of staff burnout and turnover. These efforts may even help resolve persistent staffing challenges.

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8 **Delvecchio S. Finley, FACHE: A Profile of ACHE's 2023–2024 Chair**

Delvecchio S. Finley, FACHE, will assume office as Chair of ACHE on March 18. He is president, Atrium Health Navicent, Macon, Ga.

26 **Equity Is Essential to Patient Safety: Most Organizations Are Beginning The Journey**



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Healthcare providers are realizing that without an intentional emphasis on equity, patient safety cannot truly be achieved—and they're taking steps to put into practice initiatives that lean into the nexus of those two intertwined goals.

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A Digital-First Approach to Care Redesign

As hospital leaders consider how to innovate and improve patient care in the middle of lingering workforce shortages, they might consider what UCSF Health's Robert Wachter, MD, calls a "digital-first" approach to care redesign.

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Shaping the Future of Nursing

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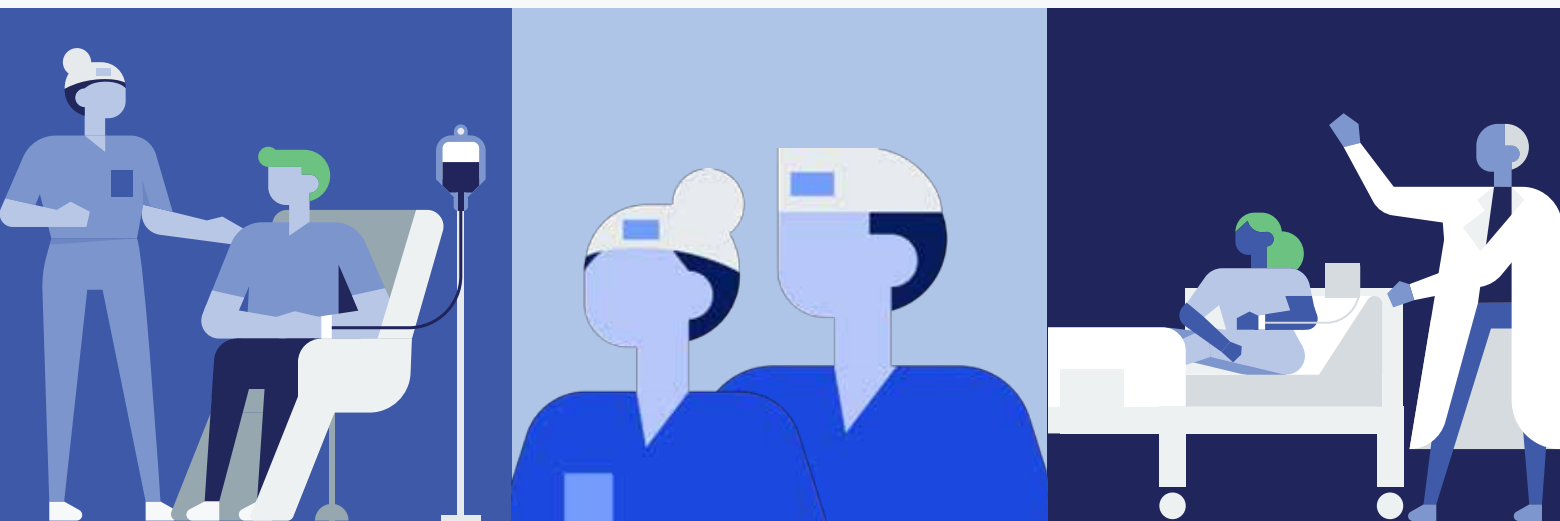
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Randy F. Liss

Delving Into Data to Improve Patient Safety

To say data is an indispensable part of healthcare today would be an understatement. Consider: The healthcare industry generates more than 30% of the world's data volume, according to RBC Capital Markets, a global investment bank. By 2025, that percentage is expected to top 36%.

All that data can be put to good use, and one area to apply it is patient safety. In this issue's cover story, "Necessary Change: Redesigning Care to Achieve Patient Safety" (Page 18), care redesign experts share various practices on how to make systems safer for patients and healthcare workers. One place they point to: the data, both to eliminate harm but also to proactively ensure that care is provided the right way more often.

Data also is critical to help health systems eliminate disparities and provide equitable care across the community, leaders and experts say in our feature "Equity Is Essential to Patient Safety" (Page 26). By parsing numbers and poring over outcomes to find gaps in care—not only by race, gender, ethnicity and age, but also sexual orientation, gender identity, education and employment status—organizations can take significant steps forward.

Finally, our profile of 2023–2024 ACHE Chair Delvecchio S. Finley, FACHE (Page 8), is inspirational reading. Finley, president of Atrium Health Navicent, Macon, Ga., assumes his new role March 18 at ACHE's Council of Regents Meeting and brings with him a passion for improving access to care in marginalized communities. Read about his professional journey and his plans for ACHE in the following year.

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

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Deborah J. Bowen,
FACHE, CAE

Prioritizing Safety Remains Job No. 1

The path to preventable zero patient harm is key to the success, safety of our workforce.

The agendas of leaders today are complex and crowded. While taking care of patients remains the primary focus, the industry continues to navigate an evolving set of workforce and financial challenges and impacts. At the intersection of these challenges lies an enormous opportunity to relaunch our safety efforts. It is uniquely suited to be the link between data and innovation, while propelling us forward to redesign care and support our patients and workforce in new ways. This one true north remains central for all of us—compelling us to do our best for the patients who put their trust in us.

It is also evident that with applied focus and effort, positive outcomes can be achieved. Take, for example, the July 2022 study published in the *Journal of the American Medical Association*, noting that in-hospital adverse events decreased between 18% and 41% from 2010–2019.

Much has happened since 2019, and we emerge knowing that our ability to hardwire lessons learned, while also closing any of the cracks that have widened in our foundation, is now central to success. In doing so, the work of safety may provide the spark that reignites, reenergizes and refuels us as caregivers and care providers, as few issues are at the heart of our work than caring for others.

A great deal has been written about safety. In 2016, ACHE partnered with the Institute for Healthcare Improvement's Lucian Leape Institute to collaborate with some of the most progressive healthcare organizations and globally renowned experts in leadership, safety and culture. Through this work, we developed *Leading a Culture of Safety: A Blueprint for Success*, an evidence-based, practical resource published in 2017 to assist healthcare leaders in creating a culture of safety. In addition, *Safer Together: A National Action Plan to Advance Patient Safety*, developed by ACHE and members of the National Steering Committee for Patient Safety, is the work of 27 influential federal agencies, safety organizations and experts, and patient and family advocates brought together by the Institute for Healthcare Improvement. Most recently, the ACHE Board of Governors updated ACHE's policy guidance for leaders, "The Healthcare Executive's Role in Ensuring Quality and Patient Safety." The impact of leaders is widely noted throughout these resources.

Though patient and workforce safety require enterprisewide systematic effort, three areas seem particularly relevant for leaders today.

Leadership fundamentals matter.

Though safety is not a new topic, its connection to current challenges may

not be so obvious and could be a useful platform. Here the vigilance of boards and leadership teams in executing a compelling vision for safety is as important today as ever. Safety governance is a foundational practice and includes the breadth of leadership activities from strategy to operational oversight and should include ongoing board education. Leadership development practices can cover core and evolving skill sets, while also providing powerful opportunities to develop key champions and strengthen collaborative problem-solving between clinical and nonclinical leaders. By measuring progress, identifying gaps in progress and learning new approaches, leaders can create sustainably safe environments and drive positive results for patients, families and the workforce.

Building trust, respect and inclusion are essential.

The everyday actions of leaders, and the behavioral standards and expectations applied across the organization, could be the most defining aspect of culture. Leaders establish the culture they value, and those norms and beliefs become the climate for all. Safety and equity are best achieved in environments that build respect, trust and inclusion through ongoing education and training, collaboration and transparency. Trust, respect and inclusion must be nonnegotiable standards that consistently apply to all, from the board room to the entire workforce.

Trust, respect and inclusive practices are also fundamental to improving outcomes for patients by building a diverse workforce capable of delivering culturally competent care and working to eliminate disparities.

(Cont. on Page 71)

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A Profile

of ACHE's 2023–2024 Chair

By Lea E. Radick

Drawn to healthcare from an early age, **Delvecchio S. Finley, FACHE**, originally wanted to become a physician and work in the Atlanta neighborhood where he was raised. “I was passionate about addressing the perceived helplessness and suboptimal mental and physical health that was pervasive in my public housing community and others like it,” he says.



During his pre-med studies at Emory University, he realized he was destined, instead, for a role in healthcare administration. Finley's passion for healthcare, particularly access to care for marginalized communities, stems from his upbringing and early work experiences.

In his formative years, Finley was blessed with a loving and devoted single mother who raised him and his siblings. Like many others, his mother unfortunately suffered from the pitfalls of drug addiction that was

rampant in his community. Finley counts himself as fortunate that his mother was able to eventually overcome her addiction, and that he didn't lose her permanently like some of his childhood friends.

"The value of service to others was instilled in me early on from my participation in student government, volunteerism and the example set by my aunt, whom I admired the most," he says. Finley's aunt was the elected tenant association president of the public housing development where he grew up.

“Delvecchio is a remarkable leader who demonstrates a passion for improving lives in everything he does, whether inside our organization or with a national platform.”

—Eugene A. Woods, FACHE

He quickly established himself within the healthcare field, becoming a CEO in his mid-30s while working at LA County/Harbor-UCLA Medical Center in Torrance, Calif., from 2011 to 2015.

In 2011, soon after becoming president and CEO of America's Essential Hospitals, Bruce Siegel, MD, visited Finley at Harbor-UCLA after hearing about his successes. “I was struck by his warmth, generosity and healthcare business acumen,” Siegel says. “He had certainly lived up to his billing.”

In later years, Finley would go on to chair the board of Essential Hospitals Institute, AEH's research and education foundation. In that role, Siegel says, Finley helped the institute grow its funding and programming, allowing it to support its member safety-net hospitals with new educational and improvement opportunities. He also helped the board examine its own work and function. That led to a clear set of expectations for every director, and served as a catalyst in the design and launch of Essential Women's Leadership Academy, an EHI program to develop rising female executives. Issues of diversity, equity and inclusion would become a primary focus of Finley's over the years.

After spending nearly 20 years of his professional life in California, in 2021, Finley returned to his home state of Georgia and joined Atrium Health Navicent as president. Macon-based Atrium Health employs over 6,000 people, has 1,116 licensed acute and specialty beds, and offers 53 specialties at more than 50 facilities throughout central and south Georgia. In December 2022, Atrium Health combined with Advocate Aurora Health to create

Advocate Health, the fifth-largest non-profit health system in the United States.

As a member of the health system's executive leadership team, Finley is responsible for providing leadership and strategic direction for the meaningful, measurable goals that will position Atrium Health Navicent's strategic growth and success. As with the strategic combination of Atrium Health and Navicent Health, his role in the newly formed Advocate

Health executive leadership team will provide thoughtful and deliberate discovery through the integration process, and position the health system to embrace market dynamics and excel.

“Delvecchio is a remarkable leader who demonstrates a passion for improving lives in everything he does, whether inside our organization or with a national platform,” says Eugene A. Woods, FACHE, one of two CEOs of Charlotte, N.C.-based Advocate Health. “And, coming from a very humble upbringing, he has never forgotten where he came from, which is especially evident in his care for our most vulnerable communities.”

Leadership: A Responsibility to Do More

During his 20 years in healthcare leadership, Finley's passion for his profession has gained the respect and admiration of many of his peers.

He is the recipient of several awards and commendations, including ACHE's 2014 Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year. He was included on *Modern Healthcare's* “Top 25 Minorities in Healthcare Watch List” and recognized with its “Up and Comers Award,” and he was named to *Becker's Hospital Review's* “Top Healthcare Executives Under 40” list. In 2021, he was also named one of *Modern Healthcare's* “Top 25 Diversity Leaders in Healthcare.” In 2022, Finley was also included on *Georgia Trend* magazine's “GEORGIA 500 list of most influential leaders.”

“This is his life's work, and he uses the platforms he has to make sure that the people in those rooms never forget

that they too—by choosing to work in healthcare—are here to serve others,” says Carmela Coyle, president and CEO of the California Hospital Association. “For Delvecchio, leadership is a responsibility to do more, not a license to do less.”

Coyle calls Finley “instrumental” not only in her selection as president and CEO of CHA—he served on the CHA board’s Executive Committee that finalized her offer to lead the organization—but also in ensuring that her transition into the role went smoothly.

“That really exemplifies who Delvecchio is—a person who gives of himself without hesitation to help others,” she adds.

Having worked closely with him for four years when he served on CHA’s Board of Trustees, Coyle describes Finley as having a “collected, thoughtful and diplomatic” demeanor when challenges arise. She also says he is a man of “impeccable integrity” and “purpose.” “I have seen him, time and again, stand up to speak on behalf of the uninsured, for people experiencing homelessness, for those facing substance use disorders,” Coyle says. “He gives voice to those who may not have one, in rooms that they are not invited to.”

Born at Grady Memorial Hospital, a safety-net hospital in Atlanta, Finley has spent most of his career working in similar hospitals and health systems.

WORK HISTORY

2021–Present

Atrium Health Navicent, Macon, Ga.
President

2015–2020

Alameda Health System, Oakland, Calif.
CEO

2011–2015

LA County/Harbor-UCLA Medical Center, Torrance, Calif.
CEO

2010–2011

California Pacific Medical Center, San Francisco
Vice President, Operations-Support and Professional Services

2009

Laguna Honda Hospital and Rehabilitation Center, San Francisco
Interim COO

2006–2009

Zuckerberg San Francisco General Hospital and Trauma Center, San Francisco
Hospital Associate Administrator, Diagnostic and Support Services

2003–2006

University of California, San Francisco
Administrative Director, HIV/AIDs Division (2005–2006)
Division Administrator, Occupational and Environmental Medicine (2004–2005)
Division Administrator, Hematology/Oncology Division (2003–2005)

ACHE HISTORY

Chair, 2023–2024
Chair-Elect, 2022–2023
Governor, 2018–2021
ACHE Regent for California—Northern & Central, 2007–2010
Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year, 2014

EDUCATION

MS, Duke University, Durham, N.C.
BS, Emory University, Atlanta

CURRENT AFFILIATIONS

Board Member, Central Georgia Health Network
Board Member, Executive Committee, Georgia Alliance of Community Hospitals
Board Member, Georgia Chamber of Commerce
Board Member, Georgia Hospital Association
Board Member, Georgia Research Alliance
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“Delvecchio seeks to move organizations to the next level. He did that for us, and he will do that for ACHE. We will all be better off as a result.”

—Bruce Siegel, MD

“When Delvecchio enters a room, people know he is there,” says Nicholas R. Tejada, FACHE, group president, Western Group-Tenet Healthcare, Dallas, who met Finley when they were both beginning their careers in California. “When he is at a meeting, his comments shape the entire discussion. And when he sets his mind on a goal, it will be accomplished. These attributes cannot be taught. Rather, they are a reflection of his role as a natural leader, in work and in life,” Tejada continues.

Although they worked for different organizations, Finley and Tejada were brought together through their active participation with the California Association of Healthcare Leaders, a local ACHE chapter. “In many ways and at many events, we would collaborate on ACHE initiatives related to early careerists as well as diversity, inclusion and equity,” Tejada says.

Giving Back to the Profession

Finley’s involvement with CAHL served as a steppingstone for his ascension as a leader within ACHE. In turn, he has been a steadfast proponent of other early careerists’ involvement with ACHE chapters, which Baljeet S. Sangha, FACHE, COO and deputy director, San Francisco Health Network/San Francisco Department of Public Health, knows firsthand.

Sangha first met Finley in 2009 soon after the early careerist had begun an internship at Zuckerberg San Francisco General Hospital and Trauma Center—part of the San Francisco Health Network.

Finley, who at the time was working concurrently as associate administrator at Zuckerberg San Francisco General

Hospital and Trauma Center and as the interim COO at the Laguna Honda Hospital and Rehabilitation Center—also part of the San Francisco Health Network—approached Sangha and asked him to serve as a student volunteer with CAHL. Finley was serving as the ACHE Regent for California—Northern & Central at the time, and he had held multiple leadership roles for CAHL, including president.

“What ensued as a result of that time Delvecchio took to vouch for my nomination to the board has been a successful and fulfilling decade of service to the health profession,” says Sangha, who is the recipient of ACHE’s 2023 Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year.

Sangha eventually went on to serve as president of CAHL in 2016 and as the ACHE Regent for California—Northern & Central from 2019 to 2022 (following in Finley’s footsteps). Sangha shares that Finley was also instrumental to his professional growth, encouraging him to earn his FACHE® credential.

As someone who views volunteer leadership as “core to my being,” Finley is grateful to ACHE for providing him with the skills and opportunity to serve. “Having an organization like ACHE where you can give back to a field that gives so much to you ... is so important,” he says.

Finley credits ACHE with contributing to his growth and success as a leader in many ways, including continuing education, networking and building a cadre of fellow leaders to rely on. His membership has also helped him to cultivate and develop new skills.

“Having that [support] really helps executives to be of increasing value to their teams, their organizations and their communities,” Finley says. “That is really the secret sauce of what ACHE does for healthcare executives.”

Confronting Today’s Challenges

Finley predicts that workforce shortages will continue to be one of the greater challenges facing healthcare

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“The value of service to others was instilled in me early on from my participation in student government, volunteerism and the example set by my aunt, whom I admired the most.”

—Delvecchio S. Finley, FACHE

executives. Although not a new challenge, per se, the scarcity of healthcare positions—mainly clinical, was exacerbated during and following the pandemic.

Rather than defaulting to status-quo solutions, such as getting more people to do the same roles, Finley suggests that leaders “look at the roles themselves and discern if there’s a different way to do the job that provides a level of scalability and sustainability.” He also suggests leaders reconsider how the field trains and develops individuals for these difficult-to-fill roles, and how to make the positions more attractive and fulfilling.

Helping to foster ACHE’s ability to provide leadership in advancing well-being and in helping healthcare workers connect to their purpose are two issues Finley plans to prioritize once he is installed as Chair of ACHE, Saturday, March 18, during ACHE’s Congress on Healthcare Leadership.

For Finley, other industries’ continued disruption of healthcare also necessitates thinking differently about how to innovate and produce value to make healthcare sustainable and affordable.

“For healthcare executives, irrespective of which sector of the field you work in—on the provider side, the insurer side, the device manufacturer side—all of us have to be thinking about how to make this thing that we care about more sustainable for everyone, including us, as leaders,” he says.

Instead of viewing challenges and solutions as separate entities, Finley sees an opportunity for them to coexist in the same space by cultivating healthcare leaders’

competence in the area of diversity, equity and inclusion.

As Chair, Finley’s other priorities include helping to foster ACHE’s ability to provide leadership in eliminating healthcare disparities *and* disparities in leadership opportunities.

By developing competence in the area of DEI, Finley believes executives can open up conversations for people from underserved populations to be con-

duits of and contributors to solutions rather than solely the beneficiaries of them. “Often, if we just ask [people from marginalized communities] to be part of the solution, we can get there faster and probably more sustainably because there’s more buy-in and ownership to it,” he says.

“I would love for this year to be viewed as more consequential than custodial,” Finley says of his term as ACHE Chair. His peers have no doubt that he is up to the task.

“I believe that Delvecchio will bring a distinct sense of energy and enthusiasm to his role as Chair,” Tejada says. “Even more, his experience serving ACHE from coast to coast will be a great asset as he works with ACHE leadership to identify and pursue opportunities to improve our profession in all of the communities we serve,” he adds.

“He is very attuned to the many ways that our field needs to transform, and I am confident he will provide the Board of Governors with the needed leadership to navigate the road ahead in his new role as Chair of ACHE,” Woods says.

“Delvecchio will ask the right questions, and he will ‘assume’ little,” says Siegel, who describes Finley as someone who leads with “collaboration and humility,” as well as a “sharp eye for business.”

“Delvecchio seeks to move organizations to the next level. He did that for us, and he will do that for ACHE. We will all be better off as a result,” Siegel adds.

Lea E. Radick is publications editor with Healthcare Executive.

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Quest Diagnostics
Secaucus, N.J.

Demand for organ transplants continues to increase. In 2021, the most recent year for data, approximately 41,354 organ transplants were performed in the U.S., a 5.9% increase over the previous year and the first time the annual total has exceeded 40,000, according to the Organ Procurement and Transplantation Network. To keep up with demand and prepare to serve the more than 105,000 patients currently on the national transplant waiting list, health systems need to find innovative ways to improve donor and patient experience while prioritizing quality and safety.

Both donors and recipients undergo extensive testing throughout the transplant journey. Therefore, high-quality testing with a quick turnaround time within a health system’s transplant diagnostics program is critical for ensuring patient care excellence. Having the right laboratory partner can help.

Improving Transplant Testing: a Comprehensive Approach

“In the wake of the pandemic, health systems are looking for ways to work more efficiently and more effectively for their patients, including in their high-cost areas, such as transplant centers,” says Ann Salm, PhD, director/medical science liaison lead, infectious disease and immunology, Quest Diagnostics, Secaucus, N.J. To help health systems improve patient experience and care outcomes and reduce costs associated with caring for patients undergoing transplant procedures, Quest offers a comprehensive

service that includes the following four solutions aimed at making key improvements.

1. Closing gaps in care. Many patients travel long distances to visit centers specializing in specific transplants. After a transplant, all patients undergo careful monitoring throughout their lives. In addition, they must undergo regular testing to prevent infections or graft failure for the initial year or two after transplant. A challenge can be making sure proper follow-up is conducted once patients are discharged and return home, especially for those who live far from the nearest transplant center.

As a national clinical lab with more than 2,200 patient service center locations across the country, Quest can help make sure patients are monitored closely—and are adhering to strict testing protocols—after they have returned home from their transplants, according to Hema Kapoor, MD, senior medical director, infectious diseases and immunology and Global Diagnostics Network, Quest Diagnostics. For example, post-transplant specimen collection materials can be sent to patients’ homes so that they can visit the nearest service center for testing convenience.

“Reaching patients where they are and making it easier for them to be tested prevents gaps in care for an improved engagement of the patient with the care team and to prevent infection, which can lead to transplant failures,” Kapoor says. “Streamlined, high-quality and sustained laboratory test results are essential.”

2. Providing accelerated results. Having quick access to test results is critical for physicians caring for patients throughout their transplant journeys. “We are committed to quick turnaround times,” Kapoor says. Quest aims to deliver testing results for donor testing within 24 hours and post-transplant infectious disease testing within eight



to 12 hours from receipt of the patient sample. Express shipping and fast tracking within the lab are available for all transplant customers, which helps expedite specimen transport and testing to support faster turnaround times.

3. Integrating patient results in the EHR. Providing clinicians fast access to post-infectious disease test results right where they need them also is critical for successful patient monitoring. Quest can integrate test results seamlessly into a health system's EHR. "We can integrate with about 800 EHR systems," Kapoor says. "Providers receive an alert on their handheld devices or right in the EHR, which allows for better monitoring of their patients in real time, helping providers make critical decisions about their patients who have received transplants and who are in a delicate balance of immunosuppression."

Clinicians also appreciate the longitudinal reporting Quest provides. Patients are monitored for post-transplant infections for a minimum of one year. Testing starts out weekly, then trails off to biweekly and monthly, for example. Clinicians benefit from knowing about patients' well-being throughout the days, weeks and months following transplant and can conveniently access that information in the EHR as well, according to Kapoor. This helps guide improved patient care and outcomes.

4. Connecting clinicians with expert help. "Post-transplant infectious disease test results can be complicated, and sometimes the physicians need help," Kapoor says. Clinicians at health systems partnering with Quest have access to a team of specialized medical experts who are available to guide test selection and results interpretation and support clinicians with patient care decisions. "The experts who are available are trained specifically in infectious diseases and have experience working in hospitals and taking care of patients," Kapoor says.

Increased access to post-transplant infectious disease surveillance and the accompanying support and solutions Quest offers all are aimed at improving transplant success rates and overall patient outcomes, say Salm and Kapoor.

"That's really our goal," Salm says. "To try and improve long-term outcomes and quality of life for patients undergoing transplant procedures."

For more information, please contact Hema Kapoor, MD, senior medical director, infectious diseases and immunology and Global Diagnostics Network, Quest Diagnostics, at HealthSystems@QuestDiagnostics.com.



NECESSARY CHANGE

Redesigning Care to
Achieve Patient Safety

By Maggie Van Dyke



Care redesign

efforts that are underway or being planned to improve patient safety and quality should continue, despite epidemic levels of staff burnout and turnover. These efforts may even help resolve persistent staffing challenges.

“There is a sweet spot where building better systems for our patients can actually reduce the moral injury or burnout that many staff are feeling now,” says Asaf Bitton, MD, executive director, Ariadne Labs, a health systems innovation center at Brigham and Women’s Hospital and the Harvard T.H. Chan School of Public Health, Boston.

“This is an incredibly hard time throughout the healthcare system, with one in five workers having left healthcare,” Bitton adds. “But I think it would be unwise to say, ‘No change initiatives for the next year because our staff are too strained and stressed.’”

There’s another critical reason to prioritize care redesign efforts: The increased use of travel nurses and other temporary workers due to staffing shortages can negatively affect teamwork and communication. “Labor challenges are creating a transitional workforce, which poses risks to patient safety and threatens the safety culture within our institutions,” says Kedar Mate, MD, president and CEO, Institute for Healthcare Improvement, also in Boston.

Given current realities, there’s a need for healthcare leaders to approach care redesign from a dual perspective. “We need to toggle between two truths,” Bitton says. “The truth that our workforce is stretched thin, and the truth that we need to redouble our efforts to make our systems safer for our patients, our healthcare workers and our communities.”

Cleveland Clinic’s two-pronged vision statement—“to be the best place to receive care anywhere and the best place to work in healthcare”—provides a pathway for addressing both of these truths. “Any care redesign effort has to have those two priorities in mind,” says Anthony J. Warmuth, FACHE, executive director for clinical transformation, Cleveland Clinic.

Interviews with care redesign experts revealed several key takeaways on how to simultaneously attain both of these goals.

TAKE WORK AWAY FROM STAFF

One key to successful care redesign is recognizing that changes to care processes must be achievable for staff to implement. “The adaptive reserve capacity of our clinicians to take on even one more extra thing is strained,” Bitton says. “So if you’re asking them to do something extra, you need to then take away some bureaucratic burden from them to create the space for change.”

One example of this approach is happening at Northwest Permanente, a large medical group in Oregon and Washington. The organization is piloting a virtual scribe program among primary care physicians to reduce their documentation burden.

“The virtual scribes are reducing our doctors’ after hours on documentation and similar tasks,” says Leong Koh, MD, president and CEO.

Northwest Permanente partners with an outside company for scribe services. Participating physicians virtually connect with the scribes and work with them to complete patient histories, medication orders and other documentation.



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for a web extra on this topic.



NECESSARY CHANGE

“It’s not only helping with patient care, but also with retaining our primary care physicians,” Koh says. “A few of our physicians say the scribe has enhanced their careers, reducing their documentation load by a couple of hours a day.”

USE QI APPROACHES AS CHANGE MANAGEMENT TOOLS

The use of quality-improvement methodologies—such as Lean and Plan-Do-Study-Act—has become ubiquitous in hospitals; however, IHI’s Mate thinks these approaches should be used more broadly.

“Often quality and safety methods get pigeonholed and used for preventing a narrow subset of conditions such as hospital-acquired infections,” he says. “But quality science is also a foundational approach to problem-solving and change management that, in my experience, is joy-restoring to the workforce.”

Mate believes every clinician should be versed in how to use quality science to solve problems they experience in the diagnostic and therapeutic process. Though many clinicians have been exposed to QI methods in school or on the job, they are not regularly using the strategies. “Unless knowledge is applied, it becomes ‘shelfware,’” Mate says.

There is a sweet spot where building better systems for our patients can actually reduce the moral injury or burnout that many staff are feeling now.

—Asaf Bitton, MD

Ariadne Labs, Brigham and Women’s Hospital,
Harvard T.H. Chan School of Public Health

One way Cleveland Clinic is arming front-line caregivers with problem-solving expertise is through its Solutions for Value Enhancement program, or SolVE. Caregivers participate in a hands-on, 12-week program, applying a formal QI problem-solving method to address a specific challenge they are experiencing in their clinical or operational areas. The program has resulted in hundreds of beneficial care improvements. “We are also developing the capacity for future improvements because our clinicians can take and apply their learnings to future problems,” Warmuth says.

UNLEASH THE DATA—AND SEEK LEARNING NETWORKS

Ideally, Mate hopes quality science will be used not only to eliminate harm but also to proactively ensure care is provided the right way more often. As an example, he points to a project at Kaiser Permanente Southern California that reduced colon cancer mortality by 24% over seven years. The team reviewed EHR records of patients who died from colon cancer to identify gaps in care or instances when patients did not receive interventions known to improve outcomes. Examples include delays in receiving chemotherapy and a lack of follow-up care for rectal bleeding. The team then enacted process improvements, as well as electronic surveillance and alerts, to help ensure colon cancer patients receive recommended care on a timely basis.

Critical to Kaiser’s successful project was the marshalling of data that already existed in the EHR, Mate says. With the growth of EHRs, this data has become widely available and accessible. “It’s no longer a technical problem,” he says. “It’s a ‘will’ problem.”

Mate encourages healthcare leaders to direct clinical analytics teams to readily produce data that can help clinicians identify diagnostic or therapeutic failures.

Bitton calls system breakdowns “know-do gaps.” “Patients suffer to a great extent because we fail to deliver the type of care we already know we should provide,” he says. “We’re so focused on new breakthrough innovations that we don’t focus enough on the ‘follow-through’ innovations, or ensuring that everyone receives the interventions we know work—equitably, effectively and on time.”

Ideally, metrics related to know-do gaps should be benchmarked internally, allowing care teams or clinicians to

compare their performance against that of a peer, and then use peer coaching to spread best practices from high performers across the system, Bitton says.

Mate also encourages hospitals to form or join regional or national learning networks that allow clinicians to share data, knowledge and best practices with peers in other organizations. A variety of learning networks already exist for specialties and diseases but more need to be created. “We need to get organizations sharing data with each other on what is taking place in their organizations to help them learn from each other about what will make patient care safer and more effective,” he says.

RECOGNIZE PATIENTS AND PROVIDERS AS THE EXPERTS

Northwest Permanente abides by two fundamentals of care redesign. The first: “Put the patient at the center,” Koh says. “When making care redesign decisions, always start with what the patient needs and what the patient wants.”

He points to the Kaiser Permanente Care at Home program, which has admitted more than 2,050 patients to advanced hospital care in the home since 2020. “Patients want to be cared for at home, and patient satisfaction scores for this program are much higher than for patients in hospital settings.”

Kaiser Permanente collaborated with a vendor to provide digital monitoring and medical equipment to hospital patients at home. Patients are carefully evaluated to determine if their care can be provided safely and effectively where they live. A command center overseen by Northwest Permanente physicians electronically monitors patients 24/7, and nurse practitioners, physical therapists and other clinicians visit patients at home.

The attention to patient safety has paid off: On average, hospital-at-home patients have lower rates of infection, mortality and readmission than patients cared for in the hospital setting.

Koh also stresses the importance of another care redesign fundamental: “You’ve got to talk to the people who provide the care. Ask physicians, nurses, medical assistants and other staff, ‘How might we make care better?’”

Northwest Permanente recently reduced wait times in urgent care by about 15% by following these care redesign fundamentals. “We saw there was a problem,” Koh says. “Then we asked our patients what they wanted and asked our staff who provided care what we could do differently, putting patient safety and quality at the forefront.”

RECOGNIZE WHEN A RADICAL DO-OVER IS NEEDED

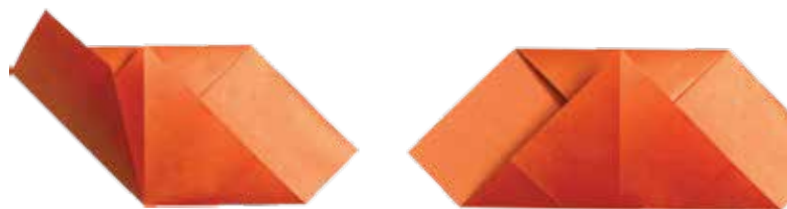
The majority of care redesign is about incremental improvement, or tweaking processes gradually over time; however, sometimes a transformative redesign is needed to achieve desired outcomes.

Warmuth calls this “starting from scratch.” “You begin by asking, ‘If we were going to build the most effective system for our patients, what would that look like?’ That doesn’t mean you have to invent everything yourself. You need to look for best practices inside as well as outside of the health-care industry that work well,” he says.

For example, Cleveland Clinic recently redesigned its sepsis response approach to ensure the deadly infections are caught early, when most treatable. Like many health systems, Cleveland Clinic used to rely on nurses in each unit to identify when their patients were showing signs of sepsis.

Now, a centralized sepsis response team monitors patients throughout the hospital 24/7. At the first sign of a sepsis infection, the team rapidly deploys and partners with the patient’s caregivers to assess and treat. The response team relies on regular conversations with bedside caregivers about their patients as well as a predictive tool in the EHR that helps pinpoint patients at risk of sepsis.

“Minutes matter with sepsis,” says Warmuth. “In our model, we have experts in sepsis proactively looking for and rapidly treating patients.”





NECESSARY CHANGE

MAKE DOING THE RIGHT THING THE EASY THING TO DO

Before implementing care redesign interventions, healthcare leaders should identify a sustainment strategy, advises Warmuth. “If the right thing to do is hard to do, then staff are going to drift back to old habits and practices. You have to think proactively about barriers to change and how you as a leader are going to lead through the change.”

Checklists or guidelines are some possible tools that can help staff navigate a new care approach. For example, Cleveland Clinic began instituting plan-of-care visits on inpatient units in 2019. During these daily bedside meetings, the care team (including at least a physician and a nurse) talks with the patient and any family members about the patient’s care, including any concerns and what to expect going forward.

The care teams are provided with structured yet flexible guidelines for how to conduct these visits, including brief scripts to use when talking with patients and specific steps to be followed at each visit. The goal is to develop collaborative treatment plans that incorporate the patients’ desires, reflect the input of all care team members and set a discharge plan.

“The plan-of-care visits are not only improving the patient experience, but also safety and quality issues, such as

The plan-of-care visits are not only improving the patient experience, but also safety and quality issues, such as ensuring that a patient’s lines and drains are removed in a timely manner.

—Anthony J. Warmuth, FACHE
Cleveland Clinic

ensuring that a patient’s lines and drains are removed in a timely manner,” Warmuth says. “In addition, these visits are reducing the workload of our nurses and physicians. Because they are having effective conversations with the patient, everyone is on the same page, which reduces misunderstandings as well as the subsequent phone calls/pages that clinicians have to deal with.”

Embedding necessary tools into the EHR is also critical to adopting new clinical interventions, says Ariadne Labs’ Bitton. He points to the Serious Illness Care Program that palliative care experts at Ariadne Labs developed. The program trains clinicians on a step-by-step process they can use to talk with patients about their medical wishes as they face serious illness or end-of-life choices. Ariadne Labs worked with national EHR companies to make it easier for clinicians to document patients’ care wishes so these requests can be easily accessed by subsequent providers in other care settings.

ASSESS READINESS AND PLOT A PATH FORWARD

Before piloting a care redesign intervention, healthcare leaders need to assess the readiness of the service line or hospital to enact the change, Bitton says. Leaders need to ask questions such as: Who are the champions who can drive implementation? Do these champions have the necessary leadership capabilities? Does the service line have the necessary resources and talent? Are the necessary data structures and communication mechanisms in place? Do they have the mental and time space for change?

Ariadne Labs has created a set of resources, called the Atlas Initiative, to help healthcare stakeholders assess readiness and implement quality-improvement projects.

“Executives are leading healthcare organizations that have many competing demands and forces,” says Bitton. “If you really want to move the organization in a certain direction, you’ve got to build clear pathways and set targets along those pathways. Extrinsic motivators can be important, but you really have to be attuned to all the intrinsic motivations that will sustainably move large complex organizations in the right direction over the long term.”

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

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Using Technology to Increase Colorectal Cancer Screening Rates

How health systems can optimize their EHRs to improve outcomes.

“By optimizing the EHR and using centralized information to direct patient care, providers can find a higher level of satisfaction and potentially lower their rate of burnout.”

—Durado Brooks, MD

Associate CMO, Screening
Exact Sciences
Madison, Wis.

A sense of collective burnout, coupled with the ongoing labor shortage and lingering care gaps caused by the pandemic, continues to weigh heavily on executives' minds. Within this environment, health systems can benefit from opportunities to optimize workflows and increase access to care, particularly for cancer screening efforts.

During the COVID-19 pandemic, there has been a severe decline in breast, colorectal and prostate cancer screenings among the U.S. population, with an estimated 9.4 million screenings not conducted that typically would have happened in 2020 alone, according to an April 2021 article in *JAMA Oncology*. Colorectal cancer remains the second leading cause of cancer mortality in the United States, according to the American Cancer Society. Because of the delays in screening caused in significant part by the pandemic, it is an opportune time for health systems to collaborate with partners in this space to close screening gaps, improve patient and provider satisfaction, and strengthen clinical and financial outcomes.

Optimizing the EHR

Health systems can find opportunities within their EHRs to streamline workflows, decrease errors and reduce

duplicative or inefficient caregiver work, which can help alleviate provider stress.

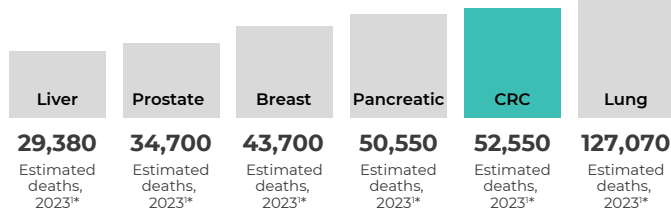
“By optimizing the EHR and using centralized information to direct patient care, providers can find a higher level of satisfaction and potentially lower their rate of burnout,” says Durado Brooks, MD, associate CMO, screening, for Exact Sciences. Both ordering cancer screenings and integrating the resulting process within the EHR can save time and ensure the care team doesn't miss important information.

Health systems can also develop “pursuit lists” within the EHR that enable providers to identify patients who can benefit from colorectal cancer screening. Alerts and notifications can be configured in the EHR to remind busy providers to discuss screenings at a current visit or follow up with the patient if an opportunity is missed.

Brooks points to a 2013 *Annals of Internal Medicine* study that showed that simply by automating patient identification, screening adherence rose by 24.5%. “If we rely on the clinician and office staff to make every individual

Early Detection of Colorectal Cancer (CRC) is Critical

CRC remains the **2nd** leading cause of cancer mortality in the United States¹ with **~53K** CRC deaths expected in 2023²



EXACT SCIENCES

identification of patients who need to be screened, a lot of people get missed,” he says.

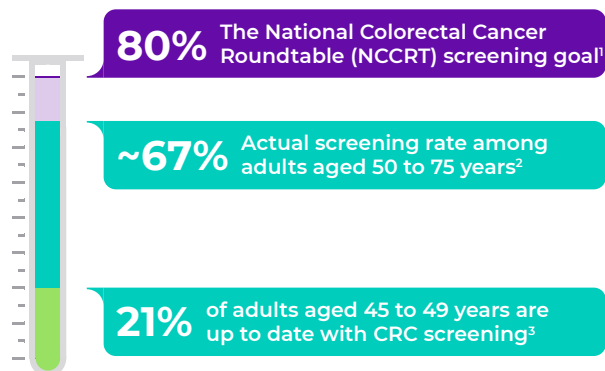
EHR-driven “population health” capabilities, Brooks says, can be especially helpful in capturing a new cohort of patients recently identified for colorectal cancer screening. In 2021, the U.S. Preventive Services Task Force changed its screening recommendations to include adults aged 45 to 49 in addition to adults aged 50 to 75. In 2022, the National Committee for Quality Assurance updated its colorectal cancer screening healthcare effectiveness data and information set, or HEDIS, measure to include adults aged 45 to 49, as well.

Health systems also can use messaging capabilities available in the patient portal to send reminders about cancer screenings, provide information about screening options and follow up about missed screenings or test results. These optimizations contribute to enhanced shared decision-making between providers and patients, which plays an important role in increasing screenings. This is particularly true when providers offer a choice of screening options, including a noninvasive test such as Cologuard®. A study published in the April 9, 2012, issue of *JAMA Internal Medicine* found that nearly two times more patients completed colorectal cancer screening when presented with two options versus being offered colonoscopy alone.

Patient Outreach and Retention

Health systems that focus on using technology to reach out to and engage patients have proven success in elevating colorectal cancer screening rates. One large health system that committed to an EHR-driven engagement approach experienced 10.1% growth in its screening rates compared to the rest of the nation’s health systems, which had a screening rate increase of around 1.5% within the

Where do your screening rates rank compared to national averages?



same time frame, according to Exact Sciences’ internal data. Exact Sciences engages with patients through the Exact Sciences Patient Navigation Program, which features on-demand phone support for patients with a Cologuard® kit order and reminder calls, texts and emails.

Engaging patients is essential to increasing screening rates and improving outcomes, especially when reaching vulnerable patients who may find it difficult to take time off from work or who may not have access to transportation, according to Brooks.

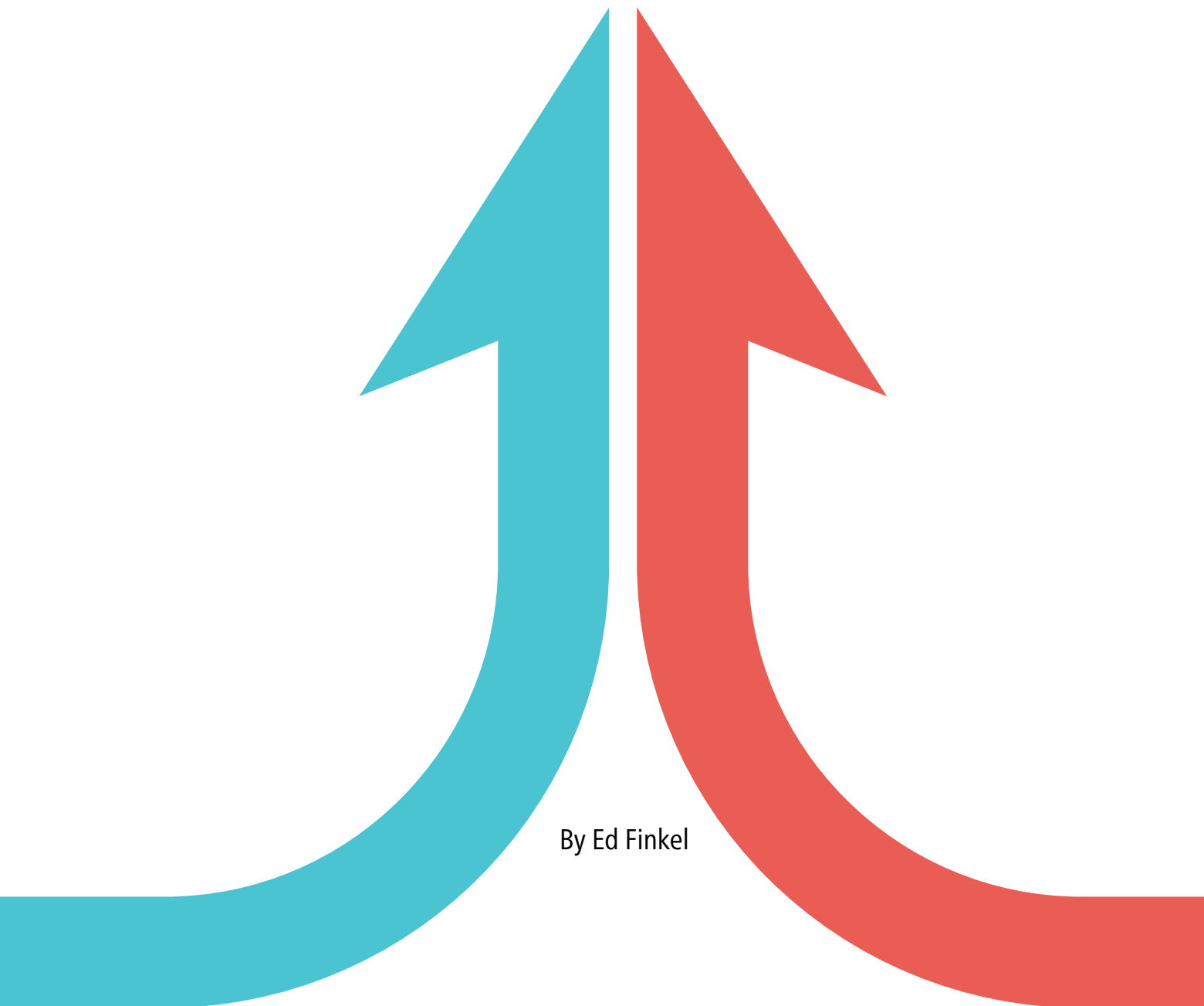
“Colorectal cancer that’s detected in its earliest stages is much easier to treat,” Brooks says. “That means there’s less burden on the patient and the healthcare system, and it’s far less expensive to treat.”

For more information, please contact Marissa Alvord, senior manager, Enterprise Collaborations, Exact Sciences, at malvord@exactsciences.com.

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EQUITY IS ESSENTIAL TO PATIENT SAFETY

Most organizations are beginning the journey



By Ed Finkel

Healthcare providers are realizing that without an intentional emphasis on equity, patient safety cannot truly be achieved—and they're taking steps to put into practice initiatives that lean into the nexus of those two intertwined goals.

The American Hospital Association has had a plethora of conversations with its members in building the Health Equity Roadmap that it launched in spring 2022 with support from the Robert Wood Johnson Foundation, says Joy Lewis, senior vice president, health equity strategies. “Everyone wants to tether this equity work to the work that’s been done for over a decade now around quality and patient safety,” she says. “Because at the end of the day, it is

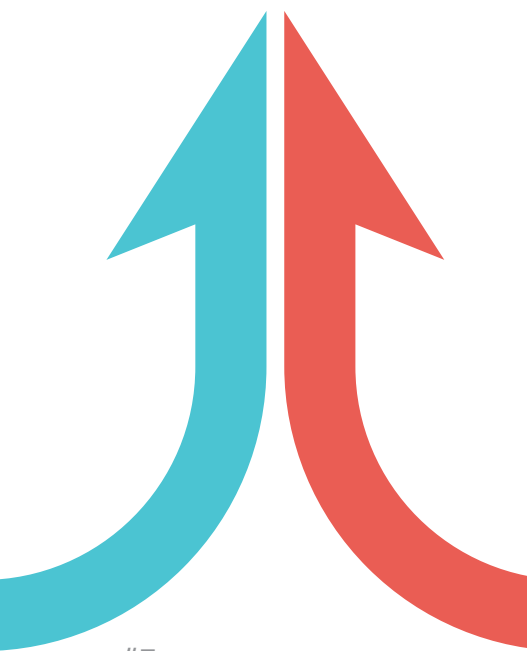
really hard to say you’re delivering high-quality care if it’s not equitably administered.”

Lewis doesn’t think much needs to be done to raise awareness of the concept, but providers do need to raise their game in parsing data and looking at outcomes by race, gender, ethnicity, age and other factors, Lewis says. “You can start to identify where there are opportunities for really targeted and focused

interventions, and what’s the right dosage of interventions that one should bring to bear,” she says.

St. Bernard Hospital and Health Care Center, located in the lower-income Englewood neighborhood on Chicago’s South Side, is well aware of the disparities, says Diahann Sinclair, St. Bernard’s vice president of organizational and community development, and an ACHE Member. “If you want your patients

EQUITY IS ESSENTIAL TO PATIENT SAFETY



“Everyone wants to tether this equity work to the work that’s been done for over a decade now around quality and patient safety. Because at the end of the day, it is really hard to say you’re delivering high-quality care if it’s not equitably administered.”

—JOY LEWIS
AMERICAN HOSPITAL ASSOCIATION

to be safe, ... you need to get to know them, and to understand how they operate, what works for them, what doesn’t work, what they are aware of, and what they’re not,” she says.

For example, a healthcare provider who serves an area with low levels of literacy shouldn’t only be giving patients written discharge instructions, Sinclair says. “Maybe you need to deliver that information in a different form,” she says. “When you do, you might find that return rates decrease and the number of instances of that occurrence decreases.”

To guard against such instances, St. Bernard uses the “teach back” method, through which clinicians explain the care plan and then ask the patient to respond with what they understand. This easily assesses comprehension and helps correct any misunderstandings.

Main Line Health, based in the Philadelphia suburb of Bryn Mawr, Pa., places safety, quality, equity and affordability as its top four priorities, says Jack Lynch, FACHE, president and CEO. “If you’re not committed to equity, you’re really not committed to safety,” he says. “Nobody suggests that being committed to safety, or high quality, is for one group of patients. It’s for everybody.”

The correlation is also a no-brainer for William Jahmal Miller, chief administrative officer of Dignity Health’s Mercy Medical Group,

CommonSpirit Health, Sacramento, Calif., and an ACHE Member.

Miller says that evidence-based research shows that patient safety and outcomes are positively correlated with culturally competent care. “There are significant improvements in outcomes for patient safety when you have more diverse, equitable, inclusive representation.”

That’s happening more often these days, but not often enough, says William “Marty” Martin, PsyD, a professor at DePaul University and an ACHE Member. “We still have far too many people dying unnecessarily within healthcare facilities or suffering from harm they shouldn’t suffer from,” he says. “People, period, but it’s exacerbated in certain groups.”

Successes to Date, Challenges to Face

AHA member organizations have begun to improve their efforts around collecting race, ethnicity and language-related information, Lewis says. “That’s probably a good place to start because of the intersectionality of race and ethnicity across these other variables,” she says. But providers have been less adept at garnering “sexual orientation and gender identity data and other demographic data, like one’s educational or employment status.

“And then how do you use those data to drive action, to really produce improvements in health outcomes?” she adds. “That’s a really

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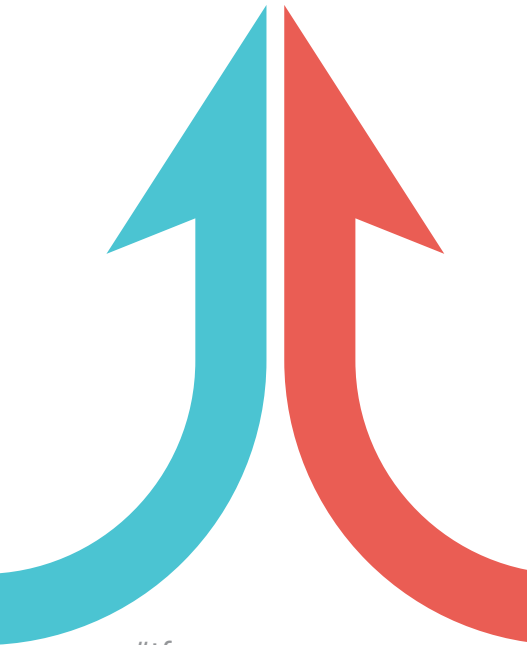
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EQUITY IS ESSENTIAL TO PATIENT SAFETY



"If you want your patients to be safe, ... you need to get to know them, and to understand how they operate, what works for them, what doesn't work, what they are aware of, and what they're not."

—**DIAHANN SINCLAIR**
ST. BERNARD HOSPITAL AND
HEALTH CARE CENTER

important nut to crack. Because if you don't understand the experience of folks coming into your hospital setting, across different patient populations, how are you going to identify where the gaps are?"

Main Line Health started its focus on equity 11 years ago, when it initiated an annual disparities-of-care colloquium at which physicians, trainees and staff present findings of research they have conducted—roughly 10 per year.

As part of their equity training, employees have been taught to say "ouch" anytime they think someone said something inappropriate or offensive, Lynch says. "You're not expected to get into a debate about why what that person says" is wrong, he says. "It's been incredibly effective at underscoring with our workforce that we don't think it's appropriate to treat people in a way that suggests that their difference is not valued."

To measure disparities, Main Line Health examines quality and safety metrics by age, gender, race, ethnicity, language, ZIP code and payer, Lynch says. "You can immediately see if a gap exists," he says. "It's right there in everybody's face. The metrics are shared with service-line leaders and clinicians, who have to develop plans around measuring gaps."

A review of patients who have averaged at least four annual ED visits led Main Line Health to note

patterns at two of its campuses that are being addressed:

On one campus, such patients were mostly from four ZIP codes, 90% were Black, 64-71% were female, who mostly ranged from 18-44 years of age. Many were presenting with urological or pregnancy-related issues.

On the second campus, two ZIP codes stood out. The patient group in one of those was 90% white, 57% female, and mostly 65 and older; that cohort presented primarily with respiratory concerns. In the second ZIP code, patients were 84% Black, 79% were female, and most were ages 18 to 44, and they presented mostly with urological and pregnancy-related concerns, similar to the four ZIP codes on the other campus.

Main Line Health has worked to ensure equity for the LGBTQ+ community as well, Lynch says, by opening LGBT-inclusive practices, switching to gender-neutral restrooms, and changing language to ensure that same-sex couples and transgender people feel welcomed, Lynch says. "We're not going to make everybody happy [with our approach]," he says. "But we need to make all groups of people who receive care from us feel good about the care they received."

CommonSpirit developed a health equity blueprint under Miller's leadership, which was finalized in the spring of 2021. Among the

strategic imperatives under the vision are to transform the system from within, “walk the talk” and identify how to address equity-related challenges and create effective diversity, equity, inclusion and belonging efforts, he says. CommonSpirit also has pledged to review how to build its data analytics to promote and support equity in a way that produces a measurable and sustainable impact. “Achieving equity is still aspirational in many instances,” he adds. “We still have a journey ahead of us.”

One area CommonSpirit has concentrated on is healthcare services to the homeless, given that having a roof over one’s head is a key social determinant of health, Miller says. “Long-term success is predicated not just on good medical care, hospitals and doctors,” he says. “It’s how can that patient go back to where they live, learn, work, play and pray and have proper social supports and continuum of care in addressing their needs?”

CommonSpirit has launched a health equity research project on peripheral artery disease, which Black Americans are twice as likely to contract as the general population, Miller says. “We’re identifying those at risk ... making sure folks are adequately screened, and moving forward with clinical and non-clinical efforts that will ultimately yield improved outcomes,” he says. “That will ultimately improve patient safety, save lives, improve

EQUITY STANDARD REQUIREMENTS BEGIN

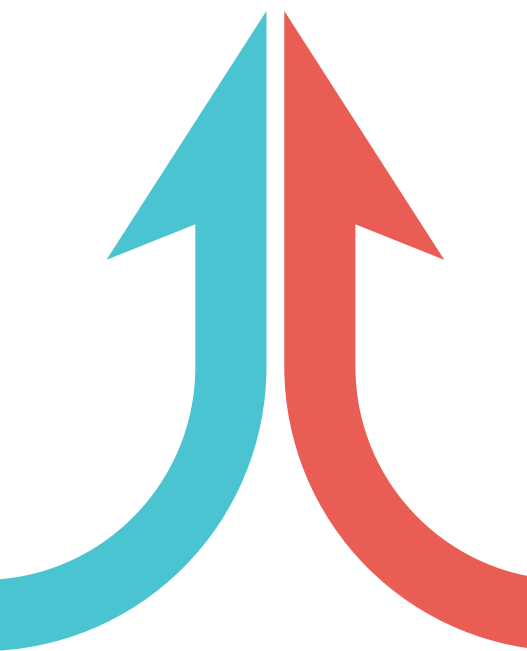
Hospitals and healthcare centers that weren’t already moving toward a more equitable culture to promote patient safety faced a few more reasons to do so as of Jan. 1, 2023, notes Joy Lewis, senior vice president, health equity strategies for the American Hospital Association.

The Joint Commission on Accreditation of Healthcare Organizations launched two standards related to equity work that took effect at the beginning of this year, Lewis says. One requires a designated equity leader “whose day job it is to be accountable for leading the equity agenda,” she says. The second covers new requirements around data related to social determinants of health, including questions like, “What are your reporting mechanisms? How are you sharing those findings, whatever the data reveal, both internally and to the board?”

On top of that, the Centers for Medicare & Medicaid Services finalized a rule last August, which also took effect on Jan. 1, that related to quality reporting requirements and equity for the Inpatient Prospective Payment System, Lewis says.

“They’ve layered on requirements around what you’re reporting out on those quality metrics,” she says. “How do you apply an equity lens to them? ... There is more momentum and energy around our members trying to figure out, ‘What is the role of hospitals and health systems in dismantling the structural barriers that impede some segments of our population from pursuing their health goals?’”

EQUITY IS ESSENTIAL TO PATIENT SAFETY



"If you're not committed to equity, you're really not committed to safety. Nobody suggests that being committed to safety, or high quality, is for one group of patients. It's for everybody."

—JACK LYNCH, FACHE
MAIN LINE HEALTH

quality-of-life, and show us what's possible when we think about equity."

DePaul's Martin has co-led efforts to reduce health disparities on the West Side of Chicago in a partnership with Rush University Medical Center, known as the DePaul/Rush Center on Community Health Equity. They reexamine scenarios like a patient who has a heart attack and lives in a high-crime area; when they go to cardiac rehab, the provider suggests they try to walk a half-mile a day. "Great, but I'm going to be at risk of being mugged or shot," the patient might respond. "Do I keep my clogged arteries, or do I get head trauma?"

That community focus starts before someone becomes a patient, Martin says. "One of the ways to decrease patient harm is to see why people are becoming patients," he says. "We focus on community health workers who keep people healthy." And the system next works to try to ensure that patients can be seen in an ambulatory setting if at all possible rather than resorting to more complicated inpatient care.

A core tenet is that while DePaul and Rush bring subject matter experts with formal education and training, they are not experts on what's happening on the ground, Martin says. Academic researchers partner with "key informants" like nonprofit executives, educators, religious leaders and small businesspeople. "We have an expertise, you have an expertise. Let's co-create and co-design," he says, "rather than being paternalistic."

The Role of Leadership

Organizational commitment to equity that advances patient safety has to start with the board, CEO and others in the C-suite, Lewis says. "You can then begin to really build out and flesh out what does that accountability across the organization look like?" she says. "How do you cascade and catalyze the workforce to see that they each have a role in being what I would describe as 'equity influencers?'"

Leaders themselves might first have to shore up their skills and acknowledge any biases, as well as ensure that their own ranks are diverse, Lewis says. "Leadership that reflects those individuals from historically marginalized groups can make more informed decisions," she says. In addition, "Leaders may consider attending community meetings, not because they have an ask, but to be present on the community's turf," she says. "There is a power dynamic we need to be very sensitive and conscious of. ... A hospital is often the largest employer [and] really the anchor institution of the communities we serve."

As the largest employer in its neighborhood, St. Bernard's takes its community leadership role seriously—and because it's a relatively small hospital, it's easy to make quick decisions, Sinclair says. "The decision-making is mainly at the senior team level, informed by what managers and practitioners are seeing," she says. "But we also partner with community groups, so whatever we deliver is done so in a manner that we know the community will receive, and also we have a trusted partner with us."

Leaders also can be receptive to hearing from people at all levels of the organization, Sinclair says, because nutrition workers, for example, who go into patients' rooms every day might get more information that may be helpful to doctors and nurses. "We've got to learn that if we're really serious about equity and safety, we've got to start listening to all the touch points, not just the ones who have certifications behind their names," she says.

Lynch believes it's important for leaders to push past divisive political rhetoric and do what's right for patients. "Why should somebody who doesn't look like me, who doesn't have the sexual orientation I have, who isn't white—why shouldn't they all get the same level of care, the same compassion, the same empathy, the same timeliness, the same access to health-care that I get?" he says. "When I decided to go into this business, I didn't look at the mirror and say, 'Make sure you take care of people who look like you really well.' I went into this business to deliver safe, equitable, high-quality care. People who don't think this is important don't belong in this business."

Leaders at CommonSpirit show a visible commitment to DEI so that women and minority groups always feel like they are part of the organization, Miller says. "We're focused on implementing routine discussions around implicit bias and being an anti-racist organization," he says. "The better we are doing that, the better able we are to treat more diverse populations."

Every organization is in a different place on that journey, Lewis says. "But we do have to be serious, and diligent, and hold each other accountable for this work," she says. "This is the long game, right? If it were easy, we would have figured it out by now."

To figure it out, providers need to move from the performative aspect of taking pledges and turn the corner to action, Lewis says. "That is really where the field is going," she says. "I know our members are chomping at the bit and are asking for the how-to's. How do I write a strategic plan that has equity embedded in it? How do I ensure that my board leadership and my executive leadership are diverse?"

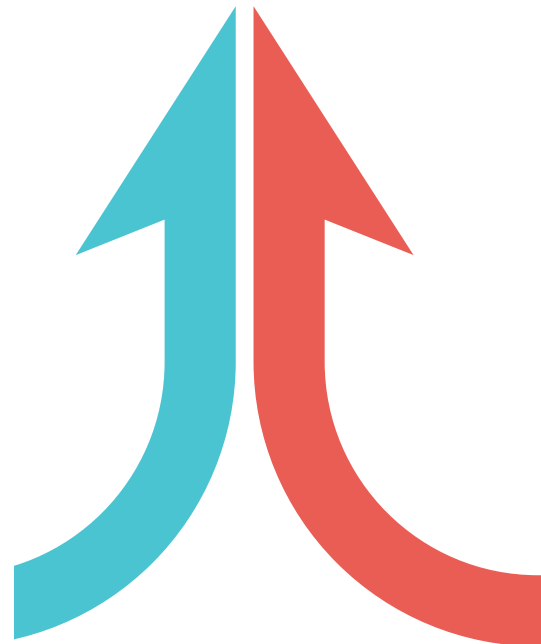
Sinclair says that leaders need to be prepared to face resistance to change, although St. Bernard's has been fortunate to have staff excited about equity work and who, often, have driven it. "You have to have your team members understand what you're doing, why you're doing it and why it's important," she says. "And once you have them connected in that way, I think you can step out of the way, and equity will move forward."

"This is a journey that will never end," Lynch says. "The first thing you have to do is be comfortable talking about it. The second thing is you have to measure it. People who say, 'We treat everybody the same,' I say, 'How do you know?' If you don't measure it, you don't know."

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

"We're identifying those at risk ... making sure folks are adequately screened, and moving forward with clinical and nonclinical efforts that will ultimately yield improved outcomes."

—WILLIAM JAHMAL MILLER
COMMONSPIRIT HEALTH



2023 Post-Acute Trends: Five Strategies to Improve Hospital Outcomes

From meeting medically complex patient needs to improving financial performance, post-acute care integration has never been more important for a hospital's overall strategy.

Learn the top trends in rehabilitation for 2023 and hear from Lifepoint Rehabilitation and Behavioral Health President Russ Bailey on how these trends are expected to impact hospitals.

Key Takeaways

Trends to prioritize in your hospital's strategic planning include:

1. **Combating the ongoing workforce crisis**
2. **Scaling chronic disease management**
3. **Leveraging flexible care models**
4. **Focus on financial stability**
5. **Growth of strategic partnerships**

1. Combating the ongoing workforce crisis

Recruiting and retaining clinical talent remains a top priority, according to a recent healthcare executive survey. Three key factors fueling this ongoing shortage include:

- **Elevated staffing costs**

Due to various COVID-19 surges, labor costs have grown 25% since 2019.¹ "It has become increasingly difficult for hospitals to keep up with service demands with a drastically declining workforce," shared Bailey. Support from a focused partner with local and national reach helps hospitals to identify and retain specialized talent.

- **Worsening experience-complexity gap**

Another shortage among the clinical workforce is experience.² "Not only are we seeing a large gap in

experienced labor, the patient population is becoming older and more complex. This has pushed hospitals to seek support from an industry expert to help alleviate this labor-patient imbalance," stated Bailey.

- **Capacity constraints**

A lack of clinical labor, treatment supplies and bed space has heightened the healthcare labor crisis. Bailey said, "These compounding factors cannot be taken on by a single hospital. Partnership allows hospitals to focus on quality care while the partner provides specialized resources and expertise to overcome challenges such as capacity constraints."

2. Scaling chronic disease management

Research notes that **more than 655,000 people in the U.S. die from heart disease each year, while nearly 800,000 experience a stroke annually.**³ "Seeing cases like heart disease and stroke drastically rise each year is just one of the many reasons hospitals are including elevated chronic disease management into their overall strategy," stated Bailey.

"When Lifepoint partners with hospitals, we bring in specialized technology, training and expertise to help equip staff with resources to succeed with their patients, no matter their condition."

3. Leveraging flexible care models

Now more than ever, hospitals are reviewing the scope and scale of their care continuum – leading to service line expansions, and an increase in ambulatory sites, digital health and post-acute care.⁴

Co-location continues to see substantial growth as patients with both physical and mental illnesses want to receive high-quality care in the same setting. This model,

also referred to as the Hospital-in-Hospital (HiH) model, helps streamline a hospital's care approach while improving outcomes and flexibility. "When you pair post-acute services under the same roof, you enable patients to reap the benefits of multiple specialty offerings without having to transfer them outside of the system," stated Bailey.

4. Focus on financial stability

Eighty-three percent of healthcare executives note that financial stability is one of their top priorities for 2023 strategic planning.⁵

"Successfully managing all aspects of a rehabilitation unit or hospital has become more financially challenging due to growing patient complexities, readmission risks and the integration of value-based care," stated Bailey. "If a hospital can achieve an effective post-acute strategy they can better manage the intricacies of the program and increase care quality in a cost-conscious way."

5. Growth of strategic partnerships

Throughout the pandemic, health leaders turned to innovative solutions to meet the growing demand in their community. Contract management and joint-venture partnerships emerged as a proven strategy to expand care in a high-quality and cost-effective manner.

"Partnership offers access to new capabilities, increased speed to market and greater efficiencies in capital, scale and operations," stated Bailey. "Lifepoint Rehabilitation helps local hospitals access a national database of quality data, greater operational efficiency and industry-leading best practices. Through this, we are able to relieve the burden of running a complex service line, enabling hospitals leadership to focus on what really matters – the patient."

To learn how Lifepoint Rehabilitation can help your hospital meet growing opportunities and stay ahead of future trends, visit [LifepointRehabilitation.net](https://www.lifepointrehabilitation.net).



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Paul B. Hofmann, DrPH,
LFACHE

Reducing Medical Debt Bankruptcies

Minimizing them is an ethical necessity.

The distressing impact from the growing number of people experiencing personal bankruptcy due to an inability to pay medical bills is indisputable. There is a remarkable \$88 billion in medical bills on credit reports, according to the Consumer Financial Protection Bureau. A March 10, 2022, Kaiser Family Foundation analysis noted that nearly one in 10 adults has medical debt, despite 90% of the population having some health insurance, according to the American Hospital Association.

While the financial costs are undeniable, they almost pale in comparison to the emotional and physical costs.

Another report issued on the same date by the Peterson Center on Healthcare and KFF indicated many households do not have enough money available to cover the cost of a typical deductible in a private health plan. About one-third of single-person households with private insurance in 2019 could not pay a \$2,000 bill, and half could not pay a \$6,000 bill. Unsurprisingly, more medical debt

is incurred by those who are ages 35 through 64 because they have greater health needs and aren't old enough to have Medicare coverage. The analysis also found, as expected, numerous people in poor health and others living with a disability had medical debt.

Real-Life Consequences of Medical Debt

As disturbing as these reports have been, the findings of a June 16, 2022, investigative project on healthcare debt conducted by KFF and Kaiser Health News in partnership with NPR revealed the personal consequences for individuals whose lives have been compromised irreversibly by medical debt. While the financial costs are undeniable, they almost pale in comparison to the emotional and physical costs.

Among the many stories shared, one patient drained her retirement account and took on three jobs after she and her husband were sued for nearly \$10,000 by a hospital where his infected leg was amputated. Another patient and her husband saw their carefully planned retirement upended when her colon had to be removed. The couple had diligently saved and had excellent retiree health insurance. Her surgery, however, led to multiple

complications, months in the hospital and medical bills that exceeded the \$1 million cap on the couple's health plan. When they couldn't pay the more than \$775,000 owed the hospital, the couple was sued and declared bankruptcy. They cashed in a life insurance policy to pay a bankruptcy lawyer and liquidated saving accounts they had set up for their grandchildren.

Considerations for Healthcare Organizations

Healthcare leaders can help prevent and reduce medical debt for their patients through the following actions:

Monitor compliance with the federal price transparency rule that requires hospitals to post all prices online. The rule, put in place Jan. 1, 2021, mandates that standard charges are made public for all items and services for all payers and all plans for at least the 300 most common procedures, as well as discounted cash prices and a standard list or price estimator.

Assess the impact of the "transparency in coverage" requirement that health insurers include the rates they have negotiated with participating providers for all covered services and items, as well as the allowed and billed amounts for out-of-network providers. This rule was made final in 2020 by the Department of Health and Human Services, the Department of Labor and the Department of the Treasury.

Become even more engaged in assisting patients and their families in determining eligibility for financial assistance and charity care.

Healthcare executives should reassess their financial assistance and charity care policies to develop a user-friendly system to aid people in applying for assistance. Hospital leaders should understand their organizations' charity care policies and make sure they are being used to their fullest.

Determine if any of your organization's debt collection agencies might engage in predatory practices. For example, if patients or their families are told they may be eligible for assistance, but the information is unclear and/or inconsistent, the practices of such agencies should be reviewed and rectified. Too often, debt collection agencies bill full charges and may receive between 25% and 50% of the money they collect.

Be Open to Unconventional Approaches

The increasing number of people coping unsuccessfully with medical debt should not be victimized by collection agencies using unscrupulous processes. No one disagrees that all abusive, unfair or deceptive debt collection practices are ethically indefensible. Similarly, there is no disagreement that healthcare organizations must be properly compensated for services they provide, whether by insurance, Medicare, Medicaid, the patient or patient's family, or charitable funds.

Consequently, when two-thirds of all personal bankruptcies are due to medical bills, according to a Feb. 6, 2019, article published in the

American Journal of Public Health by David Himmelstein et al., it is even more important that we explore how unconventional approaches in the industry can help organizations reduce medical debt, which can serve as an inspirational catalyst for hospitals to seek out similar innovations. ▲

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



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Samantha Jacques, PhD,
FACHE, AAMIF

Improving Cybersecurity for Medical Devices

Despite challenges, processes, tools and guidance are available to help.

Although many organizations have prioritized cybersecurity for software and networks made up of computers and servers, the process of protecting medical devices is much less straightforward.

Several factors make securing medical devices difficult. To start with, the life cycle of medical devices is very different from traditional IT software and hardware assets. Generally, IT assets are updated and replaced every three to five years. Medical devices, however, have a much longer life, generally seven to 10 years. This mismatch has caused issues with keeping software supported throughout the entire medical device life cycle.

Next, medical devices are regulated by the Food and Drug Administration, which requires review and approval of all new devices that enter the market. The additional time between the design of the device and product release impacts the length of time the software is supported post-release.

Another factor complicating security is that when vulnerabilities are released, patches to mitigate the risk are developed for IT systems much faster than they are for medical devices. Medical device manufacturers must develop and test patches to ensure there are no unintended consequences to a device's performance. Therefore, it can be up to

one or two years between when a vulnerability is identified and when a patch is released.

Finally, although automated tools are available to remotely push patches quickly and easily to many IT assets, such as computers and servers, these automated tools do not exist for medical devices. Patches must be manually installed on each device regularly.

Strategies for Securing Medical Devices

Despite these challenges, processes, tools and guidance are available to help secure medical devices. The key to managing cybersecurity over the life cycle of a device is coordination among several departments, including supply chain, legal, risk, clinical/biomedical engineering, IT and cybersecurity. In addition, the following are activities during each stage of the medical device life cycle that can help manage risks:

- **Assess a device's risk prior to purchasing it.** Determine if the device meets the minimum standards set by the cross-functional team managing cybersecurity. If not, weigh the risk and benefit of acquiring the device or the mitigating controls needed to ensure safety. The cost of any compensating controls should be included in the return-on-investment analysis for purchasing the device.

- **Add cybersecurity-specific contract language to purchase agreements.** This sets expectations with vendors regarding their roles and responsibilities.
- **Install and configure devices with security in mind.** Place devices on a segmented network, limit the other devices they can communicate with and close specific ports that aren't needed for device functioning. Document all this work and the baseline configuration for data backups of the devices' settings so they can be reset to factory settings in the event of a breach.
- **Create and implement a process to patch devices** (patching means to use code to update existing software or operating systems by addressing bugs or other vulnerabilities in the system). Steps in such a process include identifying vulnerabilities, tracking patch availability, physically patching the device and documenting the patch.
- **Create and implement processes to mitigate breaches that involve medical devices.** Expand the organization's incident management plan to include the clinical and operational implications of a breach that affects medical devices. Conduct semiannual tabletop exercises with the cross-disciplinary cybersecurity team and clinicians to prepare.

This column is made possible in part by Change Healthcare.

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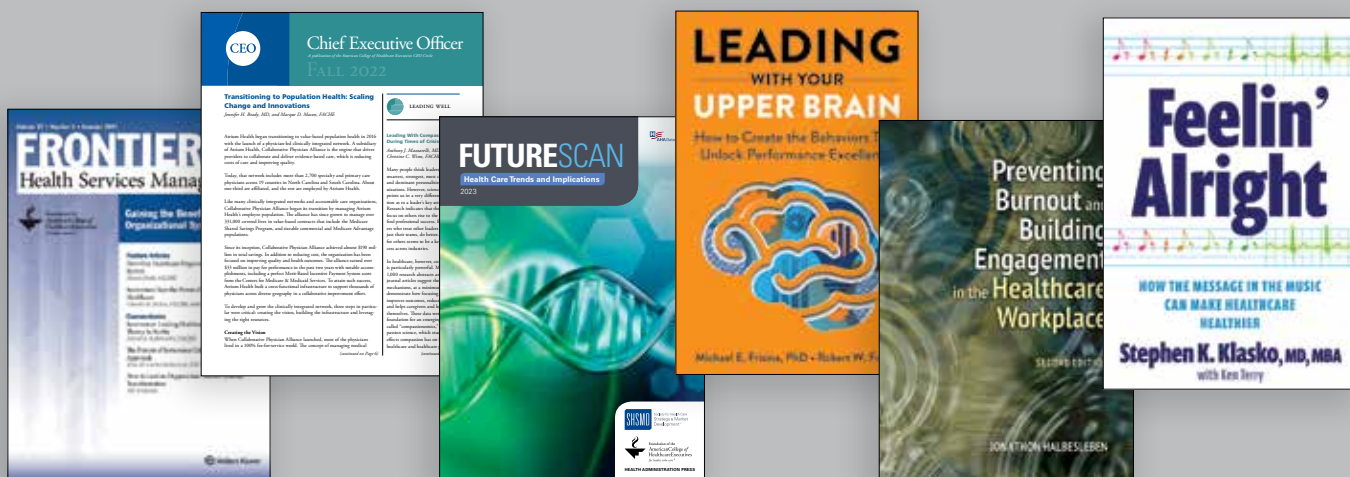
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- ***Develop an end-of-life strategy and discuss risk transfer with vendors.*** Most hospitals will not be capable of replacing all devices when the manufacturer stops supporting them. Hospitals, therefore, should identify and add compensating controls once vendors no longer generate patches. These compensating controls should be documented.
- ***Continue to review the risk of unsupported devices against the compensating controls*** in place to identify devices that require replacement. Invest the capital to replace those devices when the risk outweighs the benefit. Ensure a decommissioning process is in place to remove personal health information from

devices and software once devices are retired or removed.

Pursue Resources to Help

Many resources are available to help hospitals of all sizes and complexities. One of the most prolific in generating guidance for hospitals is the Health Sector Coordinating Council, which is part of a public-private partnership overseen by the U.S. Department of Homeland Security under the National Infrastructure Protection Plan. The HSCC serves as an official advisory council to its government counterparts—the U.S. Department of Health and Human Services and the FDA—and is responsible for coordinating strategic, policy and operational approaches to prepare for, respond to and recover from significant cyber and physical threats.

Helpful documents—available at no charge at healthsectorcouncil.org (go to “HSCC Publications” then “Recommended Practices”)—are:

- *Health Industry Cybersecurity Practices (HICP): Managing Threats and Protecting Patients* is a four-volume publication that identifies practices to manage cyberthreats and safeguard patient safety for executives, healthcare practitioners, providers and health delivery organizations, such as hospitals. The publication includes specific practices that are applicable to both small and large hospitals and hospital systems.
- *The Medical Device and Health IT Joint Security Plan* is a product life cycle reference guide. The publication covers developing, deploying and supporting secure technology solutions in the healthcare environment.
- *Model Contract-Language for Medtech Cybersecurity* offers a reference for shared cooperation and coordination between healthcare delivery organizations and medical device manufacturers regarding the security, compliance, management, operation, services and security of MDM-managed medical devices, solutions and connections. It is strongly encouraged that all medical device manufacturers, health delivery organizations and group purchasing organizations closely review this contract language and adopt as much as is appropriate.
- *The Operational Continuity Cyber Incident* checklist is intended to provide a template for operational staff and executive

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management to respond to and recover from an extended enterprise outage caused by a serious cyberattack. Its suggested operational structures and tasks can be modified or refined according to an organization's size, resources, complexity and capabilities.

- The *Health Industry Cybersecurity Supply Chain Risk Management Guide—Version 2* is a toolkit for small- to midsize healthcare institutions to better ensure the security of the products and services they procure through an enterprise supply chain cybersecurity risk management program.

The HSCC is also working on guidance for supporting legacy medical devices that at the time of this writing was due to be published in early 2023. Additionally, there is a recent update to the Health Information Technology for Economic and Clinical Health Act: If an organization documents compliance with the National Institute of Standards and Technology Cybersecurity Framework, there is a process to avoid fines should an organization's system be breached and personal health information be disclosed. Guidance from HHS on this new rule is available at hhs.gov/hipaa/for-professionals/security/guidance/index.html.

Securing medical devices is a difficult undertaking. The work to reduce the organizational risk is required, however, to ensure patient safety and continuity of care. ▲

Samantha Jacques, PhD, FACHE, AAMIF, is vice president, Clinical Engineering Services, at McLaren Health Care, Grand Blanc, Mich. (samantha.jacques@mclaren.org).

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Tuesday

Adapting TECH-THINK to Transform Healthcare for the Better

In this presentation, Lee will discuss the opportunities to use data and technology to deliver personalized care at scale, to reduce inequities and bias by applying relevant evidence-based care, and to surface the measurements that can identify and drive greater health equity across all participants in the healthcare ecosystem. If leveraged well, digital technology and analytic tools can realize the promise of precision health to advance health equity.



Vivian S. Lee, MD, PhD
**Harvard Business School,
Harvard Medical School**

The Next Phase of Retail Health and Wellness

Healthcare consumers increasingly demand more affordable, high-quality care that is convenient and easy to access. As such, retail clinics have disrupted the care delivery space and are forcing hospitals and health systems to reevaluate decades-old paradigms. Join leading experts in the retail health space as they discuss how healthcare delivery models are evolving to meet consumer demands, how retailers are shifting the landscape of healthcare, and the way these shifts will fundamentally change the U.S. healthcare system moving forward.



Caitlin Donovan
Uber Health



Rina Shah, PharmD
Walgreens



Soujanya (Chinni)
Pulluru, MD
Walmart Health

The 4th Industrial Revolution

As the CEO and founder of Zipline, Keller Rinaudo was able to imagine a use for drones that did not include instruments of war or artificial intelligence. He is at the forefront of what can only be described as the "4th Industrial Revolution"—a time in which consumers will see a huge shift toward automation in logistics and technology. Rinaudo discusses the changes we can expect from this revolution and the possibilities for how new industrialization will influence consumers' lives.



Keller Rinaudo
Zipline

Hot Topics

The 5 Hot Topic sessions at Congress highlight best practices in some of the most critical areas of healthcare leadership.

Wednesday

AHA Health Policy and Politics Update

Take a deep dive with the American Hospital Association into the intricate and shifting world of healthcare policy and politics. As hospitals and health systems continue to face unprecedented financial and workforce-related challenges, efforts to protect patients' access to care and coverage, enhance health equity and drive health system transformation are at the forefront of AHA's efforts with Congress and the administration.



Richard J. Pollack
American Hospital Association



Stacey Hughes
American Hospital Association

Responsible Innovation in the Age of Digital Health: The Expanding Opportunities for Healthcare CEOs

Healthcare executives are increasingly exerting leadership in new ways as leaders in venture capital, the payer space, health policy, pharma and private equity. The next generation of healthcare executives will need to engage in responsible innovation practices that prioritize mission and margin both for the patients they serve and their community. Presenters will share how executives can successfully create a path within healthcare organizations to set leaders up for success, and what the ideal healthcare CEO looks like now and in the future.



Stephen K. Klasko, MD
General Catalyst



Reetika Kumar, MD, FACP
Independence Blue Cross



David Shulkin, MD
Shulkin Solutions



Liz Kwo, MD
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Paul H. Keckley, PhD

Public Health Opportunities

Closer integration with local, state and federal health is key.

The latest data from the Centers for Disease Control and Prevention reveals that the public's health is deteriorating. Life expectancy is going down, infant mortality is going up, half of the adult population is dealing with at least one chronic condition and one-third suffer from a mental health disorder.

71% OF AMERICANS

favor substantially increasing federal spending on improving the nation's public health programs.

Source: Harvard T.H. Chan School of Public Health

As a result of the pandemic that took more than 1 million lives in the U.S., attention to public health has heightened: 71% of Americans favor substantially increasing federal spending on improving the nation's public health programs, while 72% believe the activities of public health agencies are extremely or very important to the health of the nation, according to a 2021 study by the Harvard T.H. Chan School of Public Health.

The CDC defines public health as “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private

communities, and individuals.” It's a noble aim. It coordinates these efforts across 3,000 community-based public health programs in addition to federal programs that address specific public health threats.

Historically, funding for public health in the U.S. has been problematic, averaging 3% of total healthcare spending for two decades, according to a 2019 *Health Affairs* article. But during the pandemic, it spiked to 5.4% and drew widespread attention to the social, economic and political significance of public health issues like COVID-19.

Case in point: The \$1.65 trillion omnibus spending package for fiscal year 2023 passed by Congress in December authorized several new public health initiatives, alongside modifications to key healthcare programs that increase access to care for vulnerable populations:

Public Health Initiatives

- **Additional CDC funding.** Its FY 2023 \$9.2 billion funding includes an 11.1% increase over 2022, with half targeted to public health preparedness programs. It also includes \$350 million in “flexible funding” to pay for public health infrastructure, such as data modernization, coordination with state and local agencies, public information

campaigns and others. The law also makes the CDC director a Senate-confirmed position.

- **Pandemic preparedness coordination.** Creation of an Office of Pandemic Preparedness and Response Policy within the White House to facilitate reports to Congress and more frequent reviews of the Strategic National Stockpile. Related is a measure that funds research within the National Institutes of Health to focus on artificial intelligence-enabled pandemic preparedness and response programs.

Enhancing Accessibility for At-Risk Populations

- **Medicaid coverage.** The bill phases in Medicaid determinations—prohibited during the pandemic—starting April 1, 2023, and allows states to permanently offer Medicaid members 12 months of postpartum coverage.
- **Telehealth.** Extends pandemic-era rules to make telehealth coverage more flexible through the end of 2024.
- **Hospital at home.** Extension of the Centers for Medicare & Medicaid Services hospital-at-home waiver through 2024 to allow hospitals to handle emergency and inpatient cases outside of a facility. (As of November 2022, 114 health systems and 256 hospitals provide home-based care.)
- **Rural hospitals.** Extension of rural hospital program funding, such as a home health rural add-on payment of 1%, federal subsidies for the education of health



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professionals serving in rural areas and the Small Rural Hospital Improvement Grant Program.

- **Opioids.** \$1.575 billion in state grants for substance use prevention and treatment, and provisions of the Mainstreaming Addiction Treatment Act, such as elimination of a Drug Enforcement Administration requirement that clinicians get an extra certification to prescribe buprenorphine; the NOPAIN Act, which improves access to Food and Drug Administration-approved non-opioid therapies for outpatient surgical procedures; and others.
- **Mental health.** Several measures funding mental health services,

including grants for maternal mental health, Medicare coverage for marriage and family counselors, and coverage for mental health counselors beginning in 2024. Also, funding for marketing and outreach efforts for the nation's new three-digit mental health hotline, 988. It transitions other mental health hotlines, including one for veterans, to the national network.

Chronic issues in public health programs—workforce adequacy, funding, data modernization and coordination between public health programs—will be mitigated in part by the omnibus bill's investments. But the most significant opportunity will be closer

collaboration between federal efforts, local public health programs and hospitals that anchor health activity in most communities.

Opportunities for Hospitals

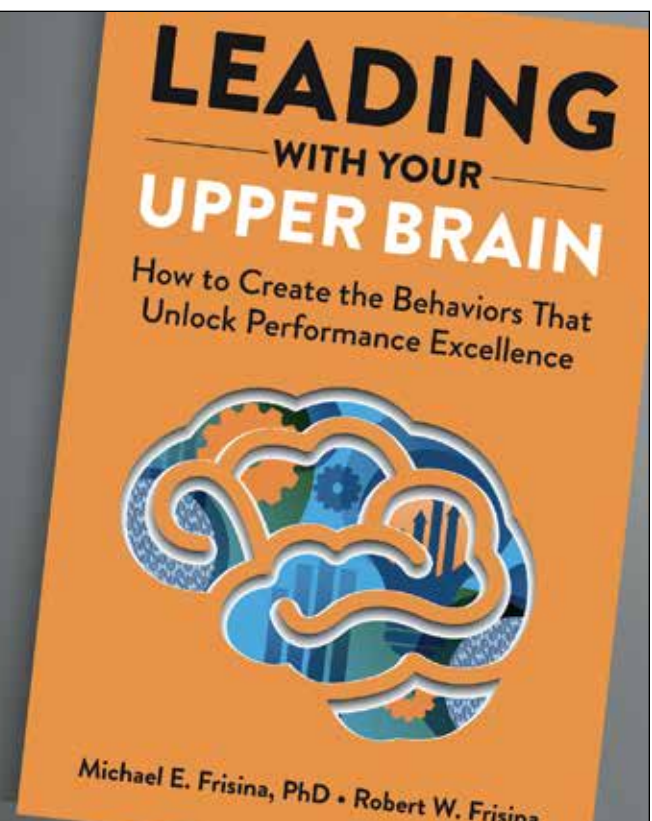
State and local public health efforts in most communities operate independent of the community's hospitals, medical practices and third-party reimbursed health services providers. The most direct connection in communities is the role played by hospital social workers in coordinating care for uninsured populations. Disease surveillance is led by state health officials, augmented by health inspectors in city and county government and by health educators in secondary and college settings. Thus, in most communities,

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the health system operates at arm's length of public health programs, leading to inadequate data gathering, higher administrative costs and compromised public health.

For local hospitals and health systems, opportunities exist to drive closer integration with local, state and federal public health apparatuses. Integration of programs, data-sharing arrangements, board representation by public health officials, cross training of workforces, and collaborative community health screening and educational activities are a start. And there are others:

- Inclusion of retail pharmacies in public health-hospital integration planning to facilitate community

awareness and access to self-care remedies that effectively obviate unnecessary hospital use.

- Integration of public health clinic EHRs with hospital ancillary and primary care services (to facilitate data sharing and surveillance).
- Protocols for a shared formulary and medication management.
- Inclusion of providers from public health clinic settings in hospital-sponsored continuing education activity.
- Joint operating agreements that eliminate duplication of hospital and public health programs.

In most hospitals today, attention to social determinants of health is a high priority; food and housing insecurity, social isolation, depression and other factors are being integrated in care coordination for patients. But in most communities, a wall exists between day-to-day hospital operations and the numerous public health programs that operate alongside them. Both serve at-risk populations, focus on community well-being and face a perplexing regulatory and economic future.

The pandemic exposed the disconnect between the health system and public health. It's also an opportunity. ▲

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



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Todd Sagin, MD, JD

Board Oversight of the Organized Medical Staff

A responsibility more important than ever.

Today's demands on hospital boards are daunting, which often is an understatement. But, as leaders work to address shrinking margins, growing clinical staffing challenges and increasing executive retirements, among a host of other issues, it is not surprising that one of the board's most important responsibilities—oversight of the organized medical staff—is often taken for granted.

[A] valuable step is a periodic board request for a thorough audit of the hospital or health system credentialing and/or peer review processes.

It is easy for board members to assume that the everyday tasks of credentialing and monitoring practitioner performance are safely on autopilot.

Unfortunately, such complacency is a mistake for a multitude of reasons that include lower patient safety and quality of care outcomes, lawsuits alleging insufficient credentialing or peer review by the medical staff, and harm to the organization's

reputation. (See sidebar on Page 49 for more.)

Now is an especially important time for governing bodies to reassure themselves that peer review, which deteriorated at many institutions during the pandemic, is back on track, uses industry best practices, and is being driven by well-prepared medical staff leaders.

Understanding Medical Staff Performance

What steps can a hospital board take to improve its understanding of the performance of the organized medical staff?

One approach is developing and using an annual credentials report that provides enlightening data regarding hospital or health system credentialing.

Such a report might enumerate the number of applications received, the amount of withdrawn or rejected applications, and the statistics regarding the length of time for application processing.

In addition, the report can show how many applicants failed to meet criteria for requested privileges, the number of waivers from membership or privileging criteria the board

granted in the past 12 months, the amount of suspensions and fair hearings, data on growth of nonphysician practitioners in the organization, or the number of distance practitioners approved for privileges. The audit might also provide information on who attended internal or external leadership training in the past year, credentialing staff turnover, or insight into how long various credentialed committee members have served as a marker of experience in this complicated field.

Another valuable step is a periodic board request for a thorough audit of the hospital or health system credentialing and/or peer review processes.

Such audits are typically performed at intervals of three to five years by a knowledgeable outside expert in the field.

Too often, such audits reveal deficiencies that have the potential to significantly hamper a hospital's ability to defend itself before accreditation surveyors, jurors in a

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corporate negligence lawsuit or in the court of public opinion.

A third approach involves ensuring medical staff leaders are trained and that the board gives full attention to its own education. The credentialing and peer review of practitioners has been an ever-changing endeavor. Too many board members are not aware

of what they don't know regarding their own role in these critical activities. Where this is the case, deficient or outright dangerous practitioners might find their way onto a medical staff, might eventually be discovered but inadequately remediated, or might bring their own lawsuits against the hospital if they believe they have been unjustly disciplined.

Though the environment is challenging, a thoughtful attitude toward the functions of the organized medical staff is paramount. ▲

Todd Sagin, MD, JD, is president and national medical director of Sagin Healthcare Consulting and an adviser with The Governance Institute (tsaginhealthcare.com).

Credentialing and Monitoring for Potential Problems

The quality of medical staff work ebbs and flows in most institutions. This is because the leadership of most organized medical staffs turns over regularly with a new cohort of relative novices stepping up as those with recently acquired experience step down. Too few hospitals make leadership education a consistent priority despite the occasional sponsorship of just-in-time boot camps for new medical staff officers, committee chairs and department chiefs. Plaintiff attorneys know this well. There has been an explosion of corporate negligence lawsuits filed against hospitals during the past decade alleging insufficient credentialing or peer review by the medical staff.

When medical staff leaders are deposed, they often reveal how little they really understand about best practices, regulatory requirements, accreditation standards and even internal policies regarding these important functions. The defense against this surge of litigation is to have strong credentialing policies and a medical staff that adheres to them rigorously. But many governing boards are unaware of how well this work is being performed.

Furthermore, in a time of tight budgets, medical staff offices are often under-resourced and barely able to deal with increasingly complex workloads. This can lead to errors that are quickly identified by plaintiffs' experts when compensation for corporate negligence is sought.

Medical staff work has become more challenging for multiple reasons, and hospital boards must ensure physician leaders are up to the task of protecting patient safety and the quality of care.

One of the most pressing new demands is the evaluation of medical staff applicants whose credentials may not have been considered in years past. A rapidly growing shortage of physicians in all specialties means that most hospital credentialing bodies will be forced to assess more individuals with some red flags in their backgrounds.

The alternative is to have medical staff vacancies that can threaten the viability of essential service lines, result in diminished hospital revenue, create long wait times for office visits that can undermine patient satisfaction and foster burnout in current

staff members who may have to bear excess workloads and hours.

Critical discussions should be taking place between hospital boards and medical staff leaders to determine where the institution will draw the line on accepting potentially problematic applicants. When such applicants are accepted to fill an unmet need, it will be critical for the board to understand the capabilities of its medical staff to adequately monitor the performance of these individuals.

During the height of the pandemic, as clinical professionals were worn to the breaking point, many medical staffs gave only perfunctory attention to peer review.

It is important that peer review consists not only of competency assessment but also appropriate interventions to remediate deficiencies. Unfortunately, few medical staff leaders are trained in such interventions or have the time to carry them out.

The presence of poorly vetted or monitored practitioners on staff can not only lead to legal liability, but also significant harm to a hospital's reputation.



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Jennifer Anderson

Solutions to the Maternal Morbidity Crisis

Care standards are showing progress.

The maternal death rate in the United States remains elevated, but there are signs of improvement as hospitals standardize care.

Maternal deaths, especially among Black pregnant and postpartum patients, are unacceptably high. According to the Centers for Disease Control and Prevention, at 23.8 deaths per 100,000 live births, the U.S. has a higher rate of maternal mortality than any other developed country. Black pregnant or postpartum patients are at least three times more likely than their white counterparts to die as a result of pregnancy; in states such as Illinois, their risk is six times greater. The COVID-19 pandemic likely exacerbated these issues, as maternal health was somewhat sidelined while hospitals managed patient surges.

As COVID-19 hospitalizations have trended downward from 2021, hospitals are steadily making progress on The Joint Commission's maternal care standards PC.06.01.01 on reducing the harm from maternal hemorrhage and PC.06.03.01 on reducing harm related to maternal severe hypertension/preeclampsia. These were introduced in January 2021 after being delayed by the pandemic. Field surveyors have

been pleased with the work accredited organizations are doing to improve their maternal care.

Recognizing that a patient with a medical emergency has recently given birth is the first safeguard against being wrongfully discharged from the ED.

Intra-Department Collaboration

This is the first time The Joint Commission has developed population-specific standards for accreditation, so there has been a great deal of awareness. Typically, The Joint Commission's hospital standards are quite broad so that they can be applied across the entire hospital, and, by contrast, the maternal health standards are very specific to the areas of the hospital that care for pregnant or postpartum patients.

Hospitals have long been accused of "working in silos," and the standards on maternal hemorrhage and maternal severe hypertension/preeclampsia necessitate a new level of collaboration. The new requirements touch

every possible department involved in patient care for a pregnant or postpartum patient, including lab, blood bank, ICU, respiratory, radiology, anesthesiology, emergency departments, obstetrics providers and, often, environmental services.

It's also not only hospitals that are held accountable for upholding the maternal health standard. It sometimes comes as a surprise to organizations not part of a typical hospital structure, but these standards extend to freestanding EDs and pediatric hospitals (in situations when the patient is under 18). The aim is not to unnecessarily create a large burden on nonobstetric hospitals; rather, it's to provide the tools to recognize a potential emergency so that the pregnant or postpartum patient can be triaged appropriately and transferred to an appropriate facility. Many of these organizations have addressed the standards quite simply by creating a process whereby postpartum patients with a pre-determined blood pressure after delivery are transferred out. The important part is that they are taking the first step in screening patients and noting when those with high blood pressure have recently delivered a baby.

Nowhere is this step more important than in the ED. It's sadly all too common for a patient to present in the hospital ED during the postpartum period with a severe headache related to an elevated blood pressure. This condition is treated very differently in, say, middle-aged men than in postpartum patients, but the distinction has not always been made. Recognizing that a patient with a medical emergency has recently given birth is the first safeguard against being wrongfully discharged from the ED.

The new requirements touch every possible department involved in patient care for a pregnant or postpartum patient.

Role-Specific Resources

Regardless of setting, the standard requires the organization to define tasks for each clinical role. Having very specific language for, say, ED nurses and different task definitions for obstetricians and/or midwives is not the norm for Joint Commission standards. In developing these standards, The Joint Commission believes it was important that every discipline that would play a role in responding to an obstetric code, such as hemorrhage or a hypertensive event, have a say in developing the organization's policy.

Role-specific education about the organization's hemorrhage and severe hypertension/preeclampsia procedures is another important component of the standards. This education—performed at orientation, whenever changes to the processes or procedures

occur, or every two years—is critical to optimal team functioning in a true emergency. Organizations are also required to conduct in-situ simulations to identify any gaps in the education or procedural issues that can be fixed prior to a real emergency.

Alignment With CMS

Along with the progress of many accredited organizations on meeting the maternal care standards, there are other advancements in this space.

The Centers for Medicare & Medicaid Services Maternal

Morbidity Structure Measures were implemented in October 2021, and the goal is to determine the number of hospitals currently participating in a structured perinatal quality improvement collaborative and whether hospitals are implementing the safety practices or care bundles as part of QI initiatives. Organizations participating in those two structural measures may be designated a “birthing friendly hospital,” pending CMS approval.

Maternal Levels of Care Verification

Looking forward to a time when organizations are proficient at preventing severe hypertension and hemorrhage, The Joint Commission continues working on its next phase in reducing maternal morbidity.

In January 2022, in collaboration with the American College of Obstetricians and Gynecologists, The Joint Commission launched a new Maternal Levels of Care Verification product that focuses on ensuring that organizations performing deliveries are providing risk-appropriate care based on their

verified level of maternal care. This on-site, perinatal program specific verification reviews an organization's ability to provide care based on the available resources. If a higher level of care is needed, then written transfer agreements are in place to get the pregnant or postpartum patient to the appropriate level of care in a timely fashion.

The Joint Commission is currently accepting applications for this program and is conducting verification surveys.

Perinatal Care Certification

The new Advanced Certification in Perinatal Care Program will address mental health, health-related social needs, safe cesarean practices, and the stratification of outcomes for pregnant and postpartum patients to name a few key topics. There are new eligibility requirements related to performance measure thresholds to ensure that organizations are performing to the highest quality. The Joint Commission developed the program in collaboration with ACOG to determine which quality and safety topics were of the utmost importance to decrease maternal death and morbidity. The application period is now open, and the first organizations are being reviewed.

Rates of maternal morbidity should never have reached this high. Together, we can progress toward providing the care that pregnant and postpartum patients in an industrialized nation deserve. ▲

Jennifer Anderson is associate director, Standards and Survey Methods, The Joint Commission (dssminquiries@jointcommission.org).



Brian E. Sweeney, RN,
FACHE

Engaging and Aligning Leaders

Jefferson Health-New Jersey's new operating model accelerates integration.

Healthcare organizations are complex, and they are evolving constantly due to never-ending changes in regulations, reimbursement, technology and models of care. Excessive busyness and resource constraints tend to distract focus from daily execution. Also, politics, bureaucracy and matrixed organizations complicate decision-making and can blur authority and accountability.

An organized, structured and coordinated approach has become paramount to achieving the desired quality, safety, financial and patient experience outcomes.

Recent crises in public health, the economy and workforce shortages brought about by the COVID-19 pandemic are demanding that healthcare leaders rethink how they get their work done each day. By putting organizational priorities into what might be thought of as an operating model, CEOs and other senior healthcare leaders in ambulatory, hospital and post-acute environments can better manage key projects and initiatives and increase their chances of fulfilling responsibilities efficiently.

An organized, structured and coordinated approach has become paramount to achieving the desired quality, safety, financial and patient experience outcomes in today's environment. Jefferson Health-New Jersey deployed such a model in its New Jersey market recently, following a merger, as a way to accelerate integration and optimize care delivery. Several core components have proven indispensable.

Keep It Simple

An operating model is not an academic exercise. It is simply a road map to functioning efficiently. It's best to not overwhelm administrative and physician leaders with theories and busywork. The objective is simply to align leaders, communicate priority initiatives, create accountability and drive action through standardized processes. Pick one or two key performance indicators for a project, not 10. Use one presentation slide for project charters, not five. The executive team will embrace this model if it is made easy for them.

Create an Operational Excellence Team

When creating a team to lead operating plan fulfillment, seek out the most talented people within an organization. Many have formal change management training in Lean Six

Sigma or project management. It's also advantageous to involve administrative fellows and interns; this is an excellent learning experience for them, and they are eager to do the work. Consider appointing an executive who is organized, accountable and passionate to lead the operational excellence team and to champion its efforts. This team will own the operating plan, manage it daily and coordinate logistics.

Solidify the Strategic Plan and Budget

Strategic planning timelines have shortened because so much is unpredictable. To ensure alignment, solidify a three-year strategic plan before developing an operating plan. This is especially important in larger systems, where strategic objectives for service lines must be synchronized with the operating divisions. Similarly, it is best that operating budgets, capital budgets and corporate key performance indicators set by the board of directors and senior executives be finalized before operators develop and launch their workplans. In larger systems, it is important to avoid duplicating efforts and resources.

Identify Key Projects and Initiatives

Prior to the start of the fiscal year, it's a good practice for CEOs and other members of the C-suite, along with physician leaders, to participate in a

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kick-off retreat to develop the annual operating plan. This gathering will engage physician leaders in the process by having them offer ideas, solve problems together, review the prior year's performance and prioritize key projects. Jefferson Health-New Jersey held a carnival-themed event this year in a tent at a golf course to maintain safety by being outside. Participants enjoyed popcorn, pretzels and cotton candy at breaks, as well as games with prizes, including duck pond, ring toss and a milk bottle toss. Of course, real work, with breakout sessions, was accomplished, too.

Much of the operating plan can be developed in a single day if this event is structured and well facilitated by the operational excellence team. Use performance data to help leaders prioritize projects so objective decisions are made. The goal of the retreat is to begin to scope these projects and narrow them to a list of no more than 20 for a 12-month period. This ultimately becomes the foundation for the operating plan.

Establish Project Teams and Plans

It's advantageous to identify project leaders and teams early. It's also recommended that the operational excellence team provide members with a package of information needed to execute their project plans. This includes education on the operating model and process, a calendar with key deadlines, project charters, "report-out" templates, and measurement tools to track results. The operational excellence team members help project teams develop plans and manage projects throughout the fiscal year. Consider having anyone involved with these key operating plan projects, including senior

leadership, attend a mandatory orientation session at the beginning of the year to ensure they understand the process, expectations and roles.

Organize Monthly Performance Reviews

It's helpful to hold monthly, consolidated operating plan performance review meetings with certain leaders, including the COO, CNO, CMO, CFO and chief quality officer. The performance review meetings at Jefferson Health-New Jersey are called SOAR, which stands for Status of Operating Plan and Achievement of Results, as the organization seeks to sail to success. Project leaders can provide a status report on their initiative, using a structured format that includes reporting KPI results, barriers, accomplishments during the past 90 days and planned activities for the next 90 days, including the person accountable for each. It's also helpful to publish a detailed reporting schedule well in advance.

Project teams, given only 10 minutes to report and field questions and answers, are forced to be succinct. For a facilitator, it's best to choose a strong leader who will have no trouble speaking up and to use standard reporting templates to keep the meeting on track. Senior leaders can be debriefed at the end of the meeting to discuss risk points, make decisions and remove barriers. Meeting minutes will ensure timely follow-up and create a culture of transparency and accountability when they are disseminated to all project teams.

Communicate, Recognize and Validate

Given the multidisciplinary nature of healthcare, hundreds (if not thousands)

of other people in an organization must be informed of the operating plan. Project plans must be translated into communication formats that are relatable and meaningful to front-line staff and physicians. A one-page visual infographic of the operating plan can be distributed through regular newsletters, town halls and manager meetings, and posted in break rooms and on the intranet. Senior leaders can round to check on the status of key projects as they interact with physicians, managers and staff, verifying results and identifying potential barriers to execution that need to be resolved. Project teams can be recognized annually to thank high performers and share lessons learned. For example, Jefferson Health-New Jersey held a Hawaiian-themed luau outside with colorful leis and a DJ.

Since implementing a structured operating model as described here, Jefferson Health-New Jersey has seen evidence of improved outcomes and created a highly engaged leadership team. The organization has maintained Leapfrog "A" safety ratings in all hospitals; achieved \$28 million in revenue enhancement or expense reductions in the last fiscal year; expanded new clinical programs in cancer, neuroscience, gastroenterology, and ear, nose and throat; and completed \$500 million of new construction projects on schedule and on budget, among many other favorable outcomes. The senior leaders of Jefferson Health-New Jersey believe this operating model is adaptable to any type or size healthcare organization across the country. ▲

Brian E. Sweeney, RN, FACHE, is regional president, North, Jefferson Health, Philadelphia.



Michael D. Pasquale,
MD

Building a Surgical Center of Excellence

Expansion, program development, innovation are elements of success.

Lehigh Valley Health Network's push to develop institutes of excellence around its most productive service lines began five years ago and includes its Institute for Surgical Excellence.

Strategies that LVHN, which provides surgical services across 13 hospital campuses spanning 10 counties in eastern Pennsylvania, used to launch its Institute for Surgical Excellence offer an example for health systems developing surgical services within their own organizations.

For LVHN's Institute for Surgical Excellence to succeed, the team first defined what success would look like, which involved a focus on three areas: surgical procedural expansion, program development and innovation. That vision has driven every aspect of the institute's development and operations.

Surgical Procedural Expansion

It was vital that consumers in the region thought of LVHN as *the* place to go for surgery. If successful, it would be because people in the communities saw no reason to go elsewhere for their surgical care.

The first step in this direction was to focus on building high volumes,

particularly with more complex types of surgical cases. The view was, and still is, that performing a large volume of surgeries across a wide range of procedures helps an organization achieve consistently positive outcomes. Currently, LVHN surgeons perform more than 70,000 procedures each year, nearly twice as many surgeries than the region's other centers.

Over 100 surgeons across more than a dozen specialties now participate in LVHN's robotic surgery program.

Program Development

This step required ensuring that the full range of surgical services needed in the community were being provided. The team reviewed existing programs, service lines and surgical divisions to identify any gaps. Several questions needed answers: In what areas were community needs not being met? Which procedures were unavailable for which services needed? Which surgical divisions needed expanded resources to create stronger programs? Based on this analysis, the team pinpointed gaps in pediatric

neurosurgery, deep brain stimulation, and head and neck surgery, among others.

Innovation

The final step involved a review across specialties, particularly for those who may have forgone care. The team identified a substantial new investment in robotics as a prime opportunity.

Though robotic technology was being used for selected procedures, by significantly expanding existing robotics capabilities, steady improvements in quality, safety, patient satisfaction and outcomes were achieved using procedures and techniques that allowed patients to resume their lives sooner, with fewer incisions; fewer infections, blood transfusions and other complications; less pain and scarring; and shorter hospital stays.

Over 100 surgeons across more than a dozen specialties now

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participate in LVHN's robotic surgery program. Areas of strength include urology, general surgery, colorectal surgery and, more recently, transplant surgery. This expansion of capabilities has enabled the health system to become the leading robotic surgery provider in the region. With solid data and metrics for support, these developments are reported in detail to senior leadership.

Robotics is a central aspect of minimally invasive care at LVHN, but it's not the only one. Expertise is being built in the use of other techniques, including high-frequency tumor ablation for the prostate and other procedures.

At the Institute for Surgical Excellence, innovation has also meant developing a team of transformative leaders for the divisions—people with academic experience who bring something new to the table and resonate with the organization's vision to be the foremost choice for surgery.

In neurosurgery, for example, the team brought in a national leader in virtual and augmented reality. Under this individual's leadership, the institute filled some of the identified gaps in pediatric neurosurgery and deep brain stimulation. Similarly, in ENT, a physician known nationally for lateral skull-based surgery will be joining the team.

A Focus on Safety

In communicating about the robotics program to the community, the strategy focused on robotics' ability to improve safety and the patient

experience. Also, a steering committee controls credentialing and monitors outcomes to provide oversight.

To keep a further watch on safety, surgeons performing procedures robotically are limited to a set number of individuals. This ensures that they are doing a high volume: five physicians, for example, performing 100 procedures rather than 100 each doing two. To date, the institute has completed more than 30,000 robotic procedures since the program's inception in 2008.

The institute has shown that as volumes and programs grow, innovation

can occur and a transformative leadership team can be built, resulting in stronger surgical services for the community.

An outcome is that trust between clinicians and senior leadership has been strengthened, as each group, through discussions, knows expectations, and all parties come away with an understanding of—and agree with—the decisions made. ▲

Michael D. Pasquale, MD, is chair of the department of surgery and physician in chief of the Institute for Surgical Excellence at Lehigh Valley Health Network, Allentown, Pa.

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ACHE MEMBER UPDATE

Interim Regents Appointed



Leech



Watson

Robert E. Leech, FACHE, chief compliance officer, Enhabit Home Health & Hospice, Birmingham, Ala., has been appointed Interim Regent for Alabama.

Kelly O. Watson, DNP, RN, FACHE, vice president/CNO, Rutland (Vt.) Regional Medical Center, has been appointed Interim Regent for Vermont.

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 as well as 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

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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.

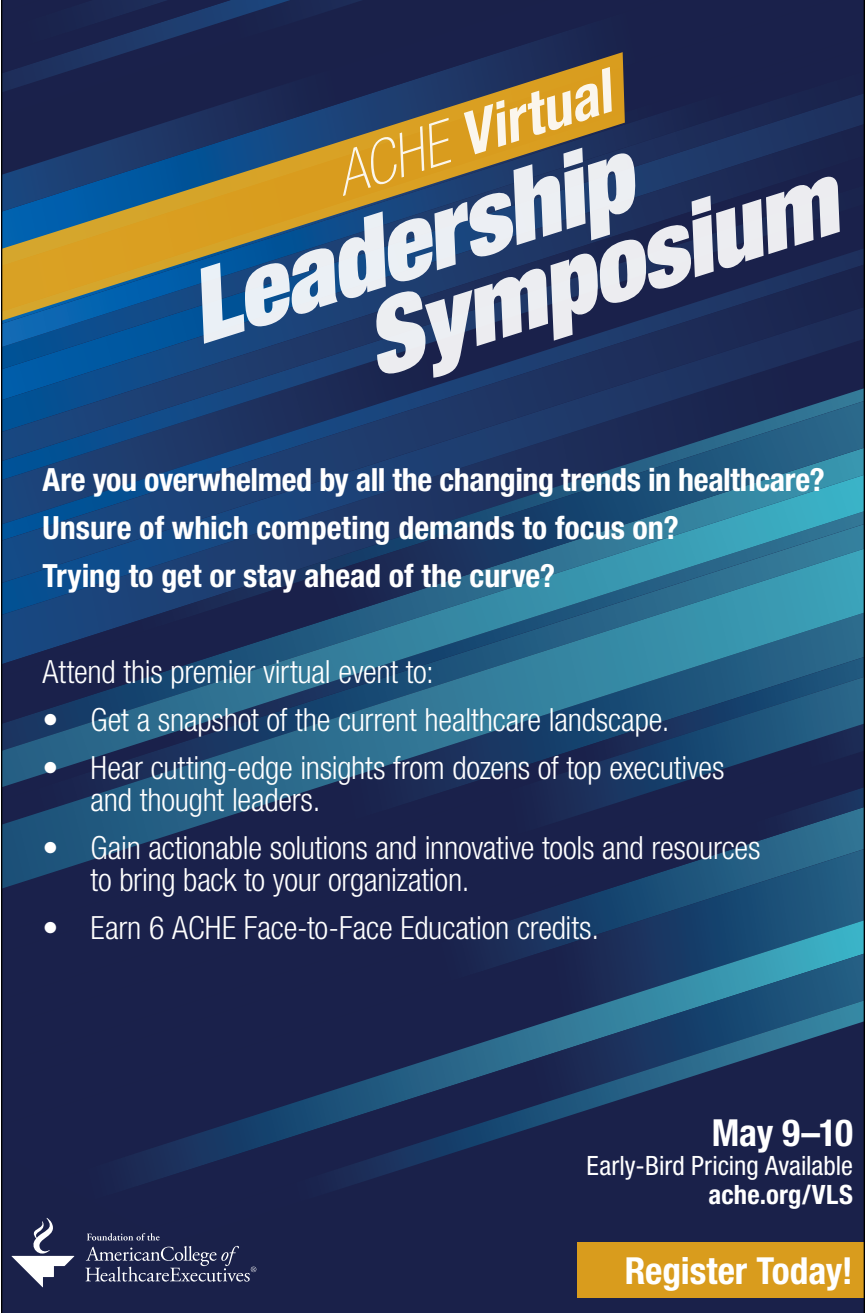
Thomas C. Dolan Executive Diversity Programs: Application Period Opens in February

The application period for the Thomas C. Dolan Executive Diversity and Career Accelerator programs will be open from February through early April. Both the Dolan Executive Diversity and Career Accelerator programs provide education, mentoring and networking experiences to prepare diverse leaders for higher-level positions in hospitals, health systems and other healthcare organizations. In 2023, the Executive Diversity Program will consist of e-learning, including live and recorded webinars, self-study materials and three in-person sessions in Chicago, Houston and Atlanta. The Career Accelerator Program will be exclusively virtual this year, consisting of 14 virtual live sessions. Dolan scholars are empowered through a structured curriculum and activities that cultivate strong leadership presence; sharpen expertise in diversity, equity and inclusion; build critical leadership skills; and expand one's capacity to navigate career opportunities and challenges. Both programs are six months in duration.

The Dolan 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 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/DiversityPrograms.

The graphic features a dark blue background with diagonal stripes in lighter shades of blue and yellow. The title 'ACHE Virtual Leadership Symposium' is prominently displayed in white and yellow text. Below the title, three key questions are listed in white text. A bulleted list of benefits follows, also in white text. The dates 'May 9-10' and the website 'ache.org/VLS' are shown in white text. A yellow button with the text 'Register Today!' is located at the bottom right. The ACHE logo is in the bottom left corner.

ACHE Virtual Leadership Symposium


Are you overwhelmed by all the changing trends in healthcare?
Unsure of which competing demands to focus on?
Trying to get or stay ahead of the curve?

Attend this premier virtual event to:

- Get a snapshot of the current healthcare landscape.
- Hear cutting-edge insights from dozens of top executives and thought leaders.
- Gain actionable solutions and innovative tools and resources to bring back to your organization.
- Earn 6 ACHE Face-to-Face Education credits.

May 9–10
Early-Bird Pricing Available
ache.org/VLS

Register Today!

 Foundation of the American College of Healthcare Executives®

LEADERS IN ACTION

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

**Delvecchio S. Finley, FACHE
Chair-Elect**

South Texas Chapter of the American College of Healthcare Executives
“ACHE Update,” Healthcare Landscape Conference 2023
San Antonio, Texas
(January 2023)

ACHE STAFF NEWS

**2022 Pickert Award Winners
Announced**



Heflin



Hodges

Shannon E. Heflin, coordinator, Development, Executive Office, and **Illana N. Hodges**, business analyst, Health Administration Press, are the 2022 recipients of the Alton E. Pickert Award, which recognizes employees who have demonstrated significant service to ACHE and its members.

The award was established by Anne M. Pickert to honor the memory of Alton E. Pickert, FACHE, ACHE Chair from 1983 to 1984. During his tenure, Pickert emphasized the important contributions of ACHE staff to the health-care field. Heflin joined ACHE in 2017. Hodges joined ACHE in 2020.

ACHE Staff Members Give Back to Community in 2022

In 2022, ACHE's staff members gave generously during the annual United Way of Metropolitan Chicago pledge drive. The team donated more than \$10,520 for United Way of Metropolitan Chicago. When combined with a \$3,000 donation from ACHE, the amount raised totaled over \$13,520.

ACHE Announces New Hires

Alexandra N. Calingo welcomed as program specialist, Department of Learning.

Andrew Prazuch, CAE, welcomed as director, Membership, Department of Executive Engagement.

Erin Ringstrand welcomed as chapter relations manager, Chapter Relations, Department of Executive Engagement.

In Memoriam

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

Douglas Carver, DDS
Golden, Colo.

Marvin J. Fischer, FACHE
Monroe Township, N.J.



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The Time Is Now to Nominate a Colleague

Gold Medal Award

The Gold Medal Award is the highest honor bestowed by the American College of Healthcare Executives on outstanding Fellows who have made significant contributions to the healthcare profession. Deadline: Aug. 16, 2023

ache.org/GoldMedal

Lifetime Service and Achievement Award

The Lifetime Service and Achievement Award was created to recognize Life Fellows and Retired Fellows who have made outstanding, nationally recognized contributions to advance the profession of healthcare management and the American College of Healthcare Executives. Deadline: July 17, 2023

ache.org/LifetimeService

Robert S. Hudgens Memorial Award

The Robert S. Hudgens Memorial Award for Young Healthcare Executive of the Year was established to recognize early careerists for outstanding achievements in the field of healthcare management. Deadline: July 17, 2023

ache.org/Hudgens

If you have any questions about the awards, contact Jennifer L. Connelly, FACHE, CAE, in the Department of Volunteer Relations at (312) 424-9320 or via email at jconnelly@ache.org.

Top Issues Confronting Hospitals: 2022

Results by ACHE's Executive Office, Research.

Workforce challenges topped the list of hospital CEOs' concerns in 2022, according to the American College of Healthcare Executives' annual survey of top issues confronting hospitals. This survey, sent in the fall to community hospital CEOs who are ACHE members, asked respondents to rank 11 issues affecting their hospitals in order of how pressing they are, and to identify specific concerns within each of those issues. The survey was sent to 1,321 community hospital CEOs, of whom 281, or 21%, responded. This year, respondents cited workforce challenges—an expanded category that includes personnel shortages—as their top concern, giving it an average rank of 1.8 on an 11-point scale. Financial challenges ranked second for the second year in a row with an average rank of 2.8. Behavioral health/addiction issues ranked third with an average rank of 5.2. The survey results are shown below.

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

Issue	2022	2021	2019
Workforce challenges (e.g., personnel shortages)	1.8	—	—
Financial challenges	2.8	4.1	2.7
Behavioral health/addiction issues	5.2	5.4	5.0
Patient safety and quality	5.9	5.0	5.3
Governmental mandates	5.9	5.4	5.2
Access to care	6.0	5.7	5.9
Patient satisfaction	6.6	6.1	6.3
Physician-hospital relations	7.6	7.8	7.1
Technology	7.7	8.1	7.7
Population health management	8.6	8.4	8.1
Reorganization (e.g., mergers, acquisitions, restructuring, partnerships)	8.7	9.4	8.7

The average rank given to each issue was used to place the issue in order of how pressing it is to hospital CEOs, with the lowest numbers indicating the highest concerns.

The survey was confined to CEOs of community hospitals (nonfederal, short-term, nonspecialty hospitals). The survey was not conducted in 2020 due to the pandemic.

Specific Concerns Within the Top Issues

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

Workforce challenges (n = 281) (e.g., personnel shortages)

Shortages of registered nurses	90%
Shortages of technicians (e.g., medical technicians, lab technicians)	83%
Burnout among nonphysician staff	80%
Shortages of therapists (e.g., physical therapists, respiratory therapists)	70%
Shortages of physician specialists	66%
Shortages of primary care physicians	65%
Shortages of advanced practice professionals	42%
Managing remote staff	32%
Other	13%

Financial challenges (n = 281)

Increasing costs for staff, supplies, etc.	89%
Reducing operating costs	66%
Medicaid reimbursement (including adequacy and timeliness of payment, etc.)	63%
Managed care and other commercial insurance payments	58%
Government funding cuts (other than reduced reimbursement for Medicaid or Medicare)	52%
Medicare reimbursement (including adequacy and timeliness of payment, etc.)	51%
Competition from other providers (of any type—inpatient, outpatient, ambulatory care, diagnostic, retail, etc.)	46%
Revenue cycle management (converting charges to cash)	43%
Inadequate funding for capital improvements	41%
Bad debt (including uncollectable Emergency Department and other charges)	38%
Transition from volume to value	30%
Emergency Department overuse	25%
Pricing and price transparency	22%
Moving away from fee-for-service	21%
Other	n = 26

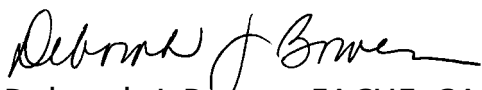
Behavioral health/addiction issues (n = 281)

Lack of appropriate facilities/programs in community	78%
Lack of funding for addressing behavioral health/addiction issues	77%
Insufficient reimbursement specifically for behavioral health/addiction services	70%
High volume of opioid addiction and related conditions	51%
Legal/regulatory framework limiting treatment options	30%
Overcoming societal judgment about mental health and substance abuse disorders	29%
Other	n = 3

Thank You to Our Premier Corporate Partners

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

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



Deborah J. Bowen, FACHE, CAE
President/CEO

American College of Healthcare Executives



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The American College of Healthcare Executives and the Foundation of the American College of Healthcare Executives held its Board of Governors meetings Dec. 5–6, 2022. The following are highlights of the meetings.

2023–2025 Strategic Plan

The Board reaffirmed the Strategic Plan for 2023. ACHE follows a three-year strategic planning cycle, and 2022 was year one. The plan builds on the progress ACHE made in adapting to the evolving climate for leaders. This includes engaging diversity partners in a next-level strategy for diversity, equity and inclusion.

In addition, the Board was updated on ACHE's education, credentialing and chapter initiatives for 2023. They include providing strong, relevant education delivered in a variety of formats, including virtual, and accelerating the digital experiences for members; building on the success of the FACHE® credential; and strengthening our partnership with chapters.

Strategic Imperatives

The Board discussed an update on the Strategic Plan's three pillars: Trusted Partner, Catalyst and Connector.

Technology Acceleration Plan

In our role as **Trusted Partner**, ACHE is committing to deepening its engagement with members and the healthcare community through education, networking and career services to inspire and cultivate leaders to advance health. In doing so, we will accelerate the use

of technology to proactively meet the challenges of a rapidly changing environment and create unparalleled digital experiences for leaders. As such, the Board has invested to ensure we use best-in-class platforms that support innovation, deliver frictionless digital access to ACHE's products and tools, and provide an integrated and personalized experience. Chief among the priorities is embarking on a website redesign.

FACHE Leadership Campaign Update

Another element of our role as **Trusted Partner** is to accelerate adoption of board certification (FACHE) as the gold standard in healthcare leadership. Work continues to develop brand foundations that will communicate the value of the credential to healthcare leaders and recruiters, qualifying members or potential members, and current Fellows.

DEI Next-Level Strategy Update

In our role as **Catalyst**, ACHE will commit to leading for equity and safety. The Board spent considerable time in 2022 developing our strategic approach to DEI, which is focused on identifying the specific competencies that drive inclusive cultures. ACHE will also pursue a partner to help develop a competency model and tools that individuals and

organizations can use. Next-level steps will be communicated as the project plan is finalized.

ACHE-Chapter Partnership 3.0 Model

In our role as **Connector**, ACHE will commit to growing our professional community across the healthcare continuum by leveraging our partnerships with chapters and other organizations. In doing so, we will identify new ways to enhance the ACHE-chapter partnership and better leverage the role of chapter leaders and volunteers in providing value to members. A project is underway to analyze the current chapter partnership and recommend refinements. More details of this work will be communicated in the second half of 2023.

Budget Approved

The Board approved the 2023 budget for ACHE and the Foundation. Within the budget, operational priorities include increasing membership and engagement, growing programming for the 2023 Congress on Healthcare Leadership and other events, and identifying new publishing opportunities.

International Update

The International Hospital Federation's 45th World Hospital Congress took place Nov. 9–11, 2022, in Dubai. The event included more than 800 registrants with a U.S. delegation of more than 60 attendees. Deborah J. Bowen, FACHE, CAE, presided as the IHF president. ACHE Chair Anthony "Tony" A. Armada, FACHE, was a featured faculty speaker. The recipient of the ACHE Healthcare Management Excellence Gold Award was Emirates Health Services (United Arab Emirates),

Mental Health of Older Adults Clinical Academic Group. In conjunction with the American Hospital Association, ACHE hosted a reception for U.S. delegates. Additionally, an ACHE Leadership Development exhibit booth helped connect attendees with our educational resources.

ACHE Learn Update

The Board was given an overview of what members can expect at the 2023 Congress on Healthcare Leadership, to be held March 20–23 at the Hyatt Regency Chicago, and other education offerings.

Congress will include over 150 education and networking sessions, including traditional signature events such as luncheons, Hot Topics and the Masters Series. Regent activities will occur on Saturday, March 18, and Sunday, March 19.

Other ACHE educational offerings this year will include a Virtual Leadership Symposium in May and in-person seminars in New York (July), Austin, Texas (October) and Orlando, Fla. (December). Popular programming, such as the Executive Program, virtual seminars, virtual Board of Governors Exam preparation and the virtual Health System Simulation, will also continue.

Committee Reports and Policy Statements

The Board reviewed reports and accepted recommendations from several committees.

These reports represent the work of hundreds of volunteers who contribute their time and talent to ACHE. In addition, the Board approved changes to several Policy Statements.

The following statements were updated:

- “Board Certification in Healthcare Management”
- *Code of Ethics*
- “Ethical Issues Related to a Workforce Reduction”
- “Ethical Issues Related to Workforce Shortages”
- “The Healthcare Executive’s Responsibility for Professionalism”
- “The Healthcare Executive’s Role in Ensuring Quality and Patient Safety”
- “Impaired Healthcare Executives”
- “Statement on Diversity”

All Policy Statements can be found at [ache.org/PolicyStatements](https://www.ache.org/PolicyStatements), and all Ethical Policy Statements can be found at [ache.org/EthicsPolicyStatements](https://www.ache.org/EthicsPolicyStatements).

FACHE Continuing Education Policy

Since September 2021, the Board of Governors has had ongoing discussions about how to evolve the FACHE credential in light of the onset of virtual offerings and the positive response to them. Temporary rules set during the pandemic allowed ACHE Face-to-Face Education credit to be awarded in certain virtual environments. These virtual options have been well-received by our members and remain in high demand, with feedback noting that virtual education is a valued component of professional development.

In December, the Board approved revised FACHE credentialing criteria. Effective Jan. 1, 2024, 36 hours of continuing education must consist of: 12 hours of In-Person Education credit, 12 hours of Virtual Interactive Education credit and 12 hours of Qualifying Education credit. For more information, visit [ache.org/FACHE-2024](https://www.ache.org/FACHE-2024).

The FACHE remains the most recognized credential of a leader’s competency and commitment to healthcare management.

Next Meeting Planned

The next face-to-face meeting of the Board of Governors is scheduled for March 17. Highlights of that meeting will be published in a future issue of *Healthcare Executive*. ▲



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

Christopher T. Ahrens, FACHE, president/CEO, Hannibal (Mo.) Regional Healthcare System, received the Senior-Level Healthcare Executive Award from the Regent for Missouri.

Christine Alvero, FACHE, senior director, Clinical Therapy Services, Moffitt Cancer Center, Tampa, Fla., received the Regent Award from the Regent for Florida—Northern and Western.

Jorge Amaro, FACHE, CEO, A3i Inc., Lake Mary, Fla., received the Senior-Level Healthcare Executive Award from the Regent for Florida—Eastern.

Peter G. Austin, FACHE, vice president/COO, Jefferson Regional Medical Center, Pine Bluff, Ark., received the Senior-Level Healthcare Executive Award from the Regent for Arkansas.

Kristi Baker, vice president, Women's & Children's Services, Saint Francis Health System, Tulsa, Okla., received the Senior-Level Healthcare Executive Award from the Regent for Oklahoma.

Tabatha Ball, COO, Agape Community Health Center Inc., Jacksonville, Fla., received the Regent Award from the Regent for Florida—Northern and Western.

April Bennett, president, Baptist Health Medical Center, Little Rock, Ark., received the Early Career Healthcare Executive Award from the Regent for Arkansas.

Alyssa L. Bruno, manager, risk and compliance, Thundermist Health Center, West Warwick, R.I., received the Early Career Healthcare Executive Award from the Regent for Rhode Island.

Maureen A. Bryant, LFACHE, received the Senior-Level Healthcare Executive Award from the Regent for Rhode Island.

John P. Carter, director, Advisory Services, Patient Physician Network, Plano, Texas, received the ACHE of North Texas Chapter Connector Regent's Award from the Regent for Army.

Kerrie Anne Ambort Clark, executive director/senior lecturer, The University of Texas at Tyler, Soules College of Business, received the 2022 ACHE East Texas Forum Chapter Connector Regent's Award from the Regent for Texas—Northern.

Damerick D. Davis, director, Operations, OB Hospitalist Group, Greenville, S.C., received the Early Career Healthcare Executive Award from the Regent for Texas—Central & South.

Anne H. Dierker, LFACHE, received the Chapter Service Regent Award from the Regent for Illinois—Central & Southern.

Shirley A. Gamble, FACHE, regional director, Operations, Kindred at Home (now CenterWell Home Health), Atlanta, received the Early Career Healthcare Executive Award from the Regent for Missouri.

Shelbi Geresi, project manager, Norman (Okla.) Regional Health System, received the Early Career Healthcare Executive Award from the Regent for Oklahoma.

DeAntony Humm, healthcare director, Genentech Inc.—South San Francisco, received the Outstanding Service 2022 Award from the Regent for Nebraska & Western Iowa.

Joseph Hwang, FACHE, COO, Beverly and Addison Gilbert Hospital, Gloucester, Mass., received the Senior-Level Healthcare Executive Award from the Regent for Florida—Northern and Western.

Tiffany C. Jackman, DHA, academic program director, University of West Florida, Pensacola, Fla., received the Regent Award from the Regent for Florida—Northern and Western.

Sujit K. Joginpally, MD, FACHE, director, Program/Unit Operations, University of Washington, Seattle, received the 2022 Regent Award from the Regent for Washington.

DeLancey Johnson, senior vice president/associate talent officer, Parkland Health & Hospital System Office, Dallas, received the ACHE of North Texas Executive Servant Leader

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

Mohammad Kharbat, FACHE, regional vice president, pharmacy Services, SSM Healthcare—Wisconsin, St. Louis, received the Regent Award from the Regent for Wisconsin.

Stephanie J. Long, FACHE, president/CEO, North Central Health Services, West Lafayette, Ind., received the Senior-Level Healthcare Executive Award from the Regent for Indiana.

Naydu Lucas, DNP, RN, CNO, Providence Health & Services, Renton, Wash., received the 2022 Regent Award from the Regent for Washington.

William B. McNally, JD, FACHE, division vice president, Membership Services, Missouri Hospital Association, Jefferson City, Mo., received the Senior-Level Healthcare Executive Award from the Regent for Missouri.

Angela A. Michael, director, performance improvement, Methodist Health System, Dallas, received the ACHE of North Texas Emerging Leader Regent's Award from the Regent for Texas—Northern.

Caramie Miskelly, workday functional analyst, Supply Chain Management, Saint Francis Health System, Tulsa, Okla., received the Early Career Healthcare Executive Award from the Regent for Oklahoma.

Eric Mooss, FACHE, president, Bryan Physician Network, Lincoln, Neb., received the Senior-Level Healthcare Executive Award from the Regent for Nebraska & Western Iowa.

David Morpeau received the Early Career Healthcare Executive Award from the Regent for Florida—Eastern.

Thomas P. Mulrooney, FACHE, COO, UnityPoint Health—Des Moines (Iowa), received the Senior-Level Healthcare Executive Award from the Regent for Iowa.

Haroula P. Norden, FACHE, COO, Boca Raton (Fla.) Regional Hospital, received the Senior-Level Healthcare Executive Award from the Regent for Florida—Eastern.

Megan Ose, PharmD, director, Pharmacy Services, Children's Hospital of Wisconsin, Milwaukee, received the Early Career Healthcare Executive Award from the Regent for Wisconsin.

Ajith Pai, PharmD, FACHE, president, Texas Health Harris Methodist Hospital Southwest Fort Worth, Arlington, Texas, received the ACHE of North Texas Executive Leadership Change Catalyst Regent's Award from the Regent for Texas—Northern.

Lana L. Palmquist, RN, manager, Clinical Integration/Acute Care Service Line, BayCare Health System, Tampa, Fla., received the Regent Award from the Regent for Florida—Northern and Western.

Pressanna J. Parackal, DNP, RN, house supervisor, UHS/VA, King of Prussia, Pa., received the Early Career Healthcare Executive Award from the Regent for Texas—Central & South.

Alexander Reyes, RN, administrator, Mennonite General Hospital, Aibonito, Puerto Rico, received the Early Career Healthcare Executive Award from the Regent for Puerto Rico.

Marla M. Sanfilippo, FACHE, received the Mid-Careerist Award from the Regent for Florida—Eastern.

Tina M. Seery, RN, senior director, safety and quality, WSHA, Seattle, received the 2022 WA Regent Award from the Regent for Washington.

Vivahni Shastry, business operations lead, Children's Hospital Los Angeles, received the Early Career Healthcare Executive Award from the Regent for California—Southern.

Karissa K. Smith, consultant, Federal Advisory Partners, Arlington, Va., received the Early Career Healthcare Executive Award from the Regent for Florida—Eastern.

Kevin W. Stevenson, FACHE, director, Strategic Operations, Ascension Providence, Waco, Texas, received the Senior-Level Healthcare Executive Award from the Regent for Texas—Central & South.

Cindy A. Stout, DNP, RN, president/CEO, El Paso (Texas) Children's Hospital, received the Senior-Level Healthcare Executive Award from the Regent for New Mexico & Southwest Texas.

Michael S. Wallace, FACHE, president/CEO, Fort HealthCare, Fort Atkinson, Wis., received the Senior-Level Healthcare Executive Award from the Regent for Wisconsin.

George Zhang, administrator, St. Vincent Health, Indianapolis, received the Early Career Healthcare Executive Award from the Regent for Indiana.

Recognizing Member Achievements

Taking time to acknowledge leaders at the local level.

During the past few months, ACHE chapters have acknowledged leaders for various efforts, as well as focused on the professional development they need in 2023. Following are examples of chapter initiatives and events that provided value for and recognition of members.

Resiliency, Recovery and Reigniting the Passion for Healthcare Leadership

Health Care Management Association of Central New York covers a wide swath of the state—a total of 41 counties are included in the chapter's reach.

The chapter serves a diverse group of healthcare leaders from various settings, including academic medical centers, integrated health systems, post-acute settings and small community hospitals, rural health providers, governmental and regulatory leaders. To address the diverse interests and backgrounds of the membership, the chapter provides a variety of educational offerings:

- Each year, an annual conference is offered with ACHE Face-to-Face Education and ACHE Qualified Education credits to support advancement to Fellow status. Also, the chapter recently

concluded a two-year offering of a Board of Governors Exam Prep Series aimed at providing best-practice education and experience from industry leaders to prospective members advancing to Fellow.

- Local program councils are offered in various markets throughout the state, including Rochester, Albany and Syracuse, to bring educational and networking opportunities to local markets to mitigate geographic challenges posed with such a large chapter reach.
- In 2023, the chapter will be evolving with a renewed focus on in-person educational and networking opportunities.

The chapter's focus is not only on the resiliency of healthcare leaders facing accelerating rates of burnout and departure from the industry but also on reigniting the spirit of caring for patients and employees. Resiliency is only the first step toward sustainability. It will focus on recovery from the pandemic's operational, financial and psychological impact, as well as reengage and reignite the passion of its leaders so they gain a deeper understanding of why they chose to work in healthcare.

The chapter also plans to collaborate with local educational institutions and other affiliated organizations, provide networking events throughout the state to reconnect with colleagues and contacts within the field, and reestablish itself as a leading resource in New York for healthcare leaders and students.

In 2023, Health Care Management Association of Central New York will be evolving with a renewed focus on in-person educational and networking opportunities.

ACHE of South Florida 2022 Fellow Celebration and Networking Event

This Fellow-only event celebrates a key constituent of ACHE, recognizing the attainment of the gold standard in healthcare management certification. The occasion is also an opportunity to applaud Fellows' commitment to lifelong learning and contributions to the field, ACHE and the chapter.

"It was an honor to recognize and celebrate our chapter Fellows and Life Fellows, share the great offerings and assets that ACHE has to offer, and make a call to action to Fellows to give back to the chapter as committee and board members, Regents, speakers and mentors to members, especially prospective Fellows," says Oyinkansola "Bukky" Ogunrinde, the chapter's 2022 president.

In addition, the chapter's 170 Fellows and Life Fellows were recognized

along with a special acknowledgment of the 2022 Fellows on the chapter's LinkedIn page.

The inaugural Fellow event was held in 2021 virtually and featured keynote speaker Matthew A. Love, president/CEO of Nicklaus Children's Health System. In 2022, the first in-person event, which was sponsored by Memorial Healthcare System, was held and the chapter presented its inaugural Chapter Fellow Service Award.

David Smith, FACHE, executive vice president/CFO, Memorial Health System, has served on the chapter's finance committee during the past two years as a speaker and is a mentor to many ACHE members and Fellows. Given his service and commitment to the chapter, he became the first recipient of the prestigious 2022 Chapter Fellow Service award.

"I am humbled to receive the ACHE of South Florida chapter's first Chapter Fellow Service Award. As a CFO, I felt that becoming a Fellow was important to deepen my connection to our patients and our mission. ACHE offers so many opportunities to learn and grow and advance your career, and giving back through volunteering helps me keep that connection. Thank you, South Florida Chapter, for this great honor," said Smith.

"This event reflects the appreciation of ACHE of South Florida for its Fellows, who show the deepest commitment and dedication," says Jenna Merlucci, FACHE, who serves as the 2022 president-elect and oversaw the production of this successful event.

DEI Recognition in Michigan

At its annual meeting in November, the Great Lakes Chapter of the American College of Healthcare Executives honored one individual and two organizations who exemplify its values around diversity, equity, belonging and inclusion with its DEBI Awards:

- Kimberly L. McVicar, DHA, an associate professor at Ferris State University, was selected for expanding her personal knowledge of these values, promoting them in her classroom, and for authoring chapters, books and published articles on DEI.
- MyMichigan Health was selected for its explicit focus on diversity and inclusion in its Vision 2025, DEI Advisory Committee, and a dedicated team within human resources to improve hiring and promotion from a DEI perspective.
- Sparrow Health System was selected for its ongoing commitment to DEI, including its adoption of eight key DEI principles for improvement, Women in Leadership program, DEI Leadership Development Program and development of implicit bias training.

The chapter congratulates them for their extraordinary accomplishments and inspiration. ▲

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

(Cont. from Page 6)

The words and actions of leaders are the secret sauce that can glue together or divide an organization and determine the impact it will achieve for its communities.

Developing the workforce is a must. An essential component of patient safety is the physical and psychological safety of the workforce. Supportive and healthy work environments are characterized by continuous learning, ongoing support, professional growth, teamwork and transparency. Policy and practice must go hand in hand. Organizations that invest in the workforce note the benefits of helping care providers reconnect with the meaning of their work, while driving higher engagement and satisfaction and reducing the likelihood of burnout. Finding new and creative ways to support every person in the continuum of care helps to deliver more effective and safer care for all.

Providing safe patient care is our primary mission as healthcare leaders, and at the core of that mission is the safety of patients, families and our workforce. By reinvigorating our focus, we can identify new ways to use safety principles and tools to make meaningful strides on our journey toward the ultimate goal of preventable zero patient harm for all. ▲

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



Baise



Henson



Koch



Mooss



Van Blaricum



Winebarger

J. Craig Bailey, FACHE, to Denver market CEO, Reunion Rehabilitation Hospital, Denver, from multisite administrator, Audubon Ambulatory Surgery Center, Colorado Springs, Colo.

Patricia Baise, DNP, RN, FACHE, to chief nursing executive, ECU Health, Greenville, N.C., from vice president/chief nurse executive, Atrium Health Cabarrus, Concord, N.C.

Johnny P. Ball III, FACHE, to senior vice president, regional hospital operations, South Georgia Medical Center, Valdosta, Ga., from vice president, marketing and public affairs.

LCDR Manuel H. Beltran, FACHE, to aide-de-camp, Commandant of the Marine Corps, The Pentagon, Washington, D.C., from chief of medical plans and operations, United States Pacific Fleet, Pearl Harbor, Hawaii.

Susan Bosnick-Sinift, RN, FACHE, to senior director, surgical services, WellSpan Health, York, Pa., from director, perioperative services, Houston Methodist Hospital.

Joseph du Lac to senior vice president/COO, Bronson Battle Creek (Mich.) Hospital, from regional vice

president/chief performance officer, Trinity Health of New England, Hartford, Conn.

Matthew K. Garner, FACHE, to CEO, Broward Health North, Lighthouse Point, Fla., from interim CEO.

Lily J. Henson, MD, FACHE, to president/CEO, Piedmont Augusta (Ga.) Hub, from CEO, Piedmont Henry Hospital, Stockbridge, Ga.

Erich Koch, FACHE, to executive director, Rolling Hills Clinic, Corning, Calif., from CFO, Valley Health Partners, Allentown, Pa.

Steven G. Littleton, DBA, to president, Bridgton (Maine) Hospital, in addition to his other role of president/CEO, Central Maine Healthcare, Lewiston, Maine.

Toby Marsh, RN, FACHE, NEA-BC, to regional chief nursing executive/vice president, clinical integration, Kaiser Permanente Northern California region, from chief nursing and patient care services officer, UC Davis Medical Center, Sacramento, Calif.

Martha S. Mather, FACHE, to COO, Aware Recovery Care, Indianapolis, from CEO, UofL Health—Peace Hospital, Louisville, Ky.

Emily S. Moorhead, FACHE, to president, Detroit-based Henry Ford Health's hospital in Jackson, Mich., from interim president.

Eric Mooss, FACHE, to president/CEO, Bryan Medical Center, Lincoln, Neb., from president, Bryan Physician Network, Lincoln, Neb.

Jackie (DeSouza) Van Blaricum to president, HCA Healthcare Far West Division, Las Vegas, from CEO, Riverside (Calif.) Community Hospital.

Adam Winebarger, DNP, RN, FACHE, to CNO/director, operations, Novant Health Ballantyne Medical Center, Charlotte, N.C., from associate CNO, LifeBridge Health Sinai Hospital, Baltimore.

Peter J. Wright, FACHE, to CEO, Northwestern Medical Center, St. Albans, Vt., from president, Bridgton (Maine) and Rumford (Maine) Hospitals.

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