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A remarkable array of digital resources that offer convenience, enhance quality and improve patients' lives are being rolled out. This article profiles three organizations, all leaders in digital innovation.

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Amid high burnout rates and staffing shortages, artificial intelligence is enabling healthcare to improve care management, quicken diagnoses and streamline clinician workflow.

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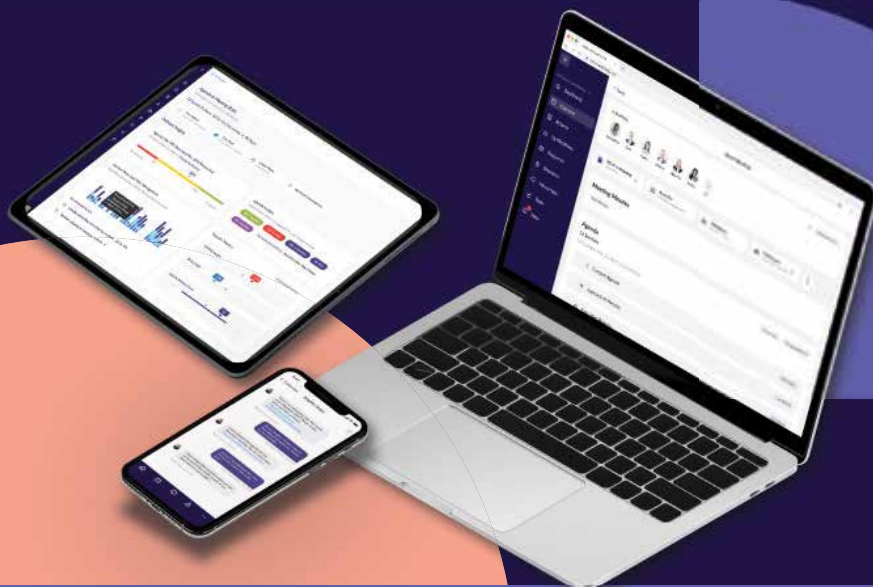
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Tech Solutions Are Advancing Care

Emma O'Riley

If healthcare's long-awaited digital transformation could be considered by some to be stuck in neutral just a few years ago, it appears to be approaching full speed today. From primary care technologies to virtual care capabilities to operational tools, organizations are adopting innovative solutions that are advancing patient care and streamlining processes. With this being *Healthcare Executive's* technology issue, you'll find examples of all that and more.

For instance, our cover story, "The Digital Outlook: Examining Tech Advancements" (Page 8), showcases three leaders in digital innovation that have introduced resources offering convenience, enhanced quality and improved patient experiences. Two of these organizations—a cancer center and a hospital—are structured in ways that place their respective digital health and innovation centers at the forefront of their digital strategy. Meanwhile, a third is offering a full suite of digital therapeutics services designed to help patients better manage their conditions at home.

Our second feature, "True Intelligence: Where AI Is Working Today" (Page 20), looks at how healthcare organizations are using artificial intelligence to improve care management, quicken diagnoses and streamline clinician workflow. With healthcare's use of AI still in its infancy, we also explore its limitations and challenges, along with considerations for leaders who are contemplating an AI solution.

Be sure to also read through ACHE's annual *Key Industry Facts*, a helpful guide to national financial indicators in healthcare. Visit **HealthcareExecutive.org/KIF**.

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

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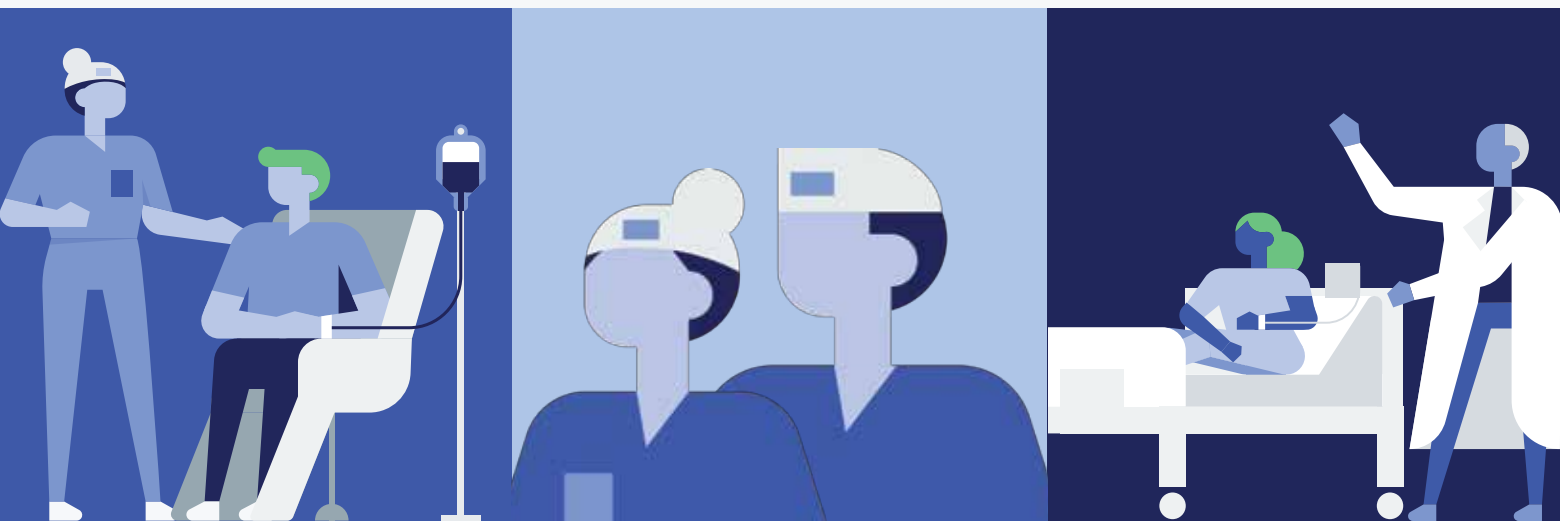
Differentiating Skills for Resilience

Prioritizing the right competencies can lead to resilient teams

Deborah J. Bowen,
FACHE, CAE

Of all the ways healthcare in the United States is evolving today, one of the most significant is in its sheer size and scope. Employment in healthcare occupations is projected to grow 16% through 2030, according to the U.S. Bureau of Labor Statistics. That makes our already wide-ranging industry the fastest growing, with about 2.6 million new jobs expected to be added by the start of the next decade.

That growth is expanding the boundaries of what a career in healthcare could be. Roles in such areas as telehealth, patient experience and value-based care are becoming more permanent, according to a survey of executives by healthcare staffing company AMN Healthcare. Meanwhile, the Association of University Programs in Health Administration recently identified several curriculum content areas as educational priorities for the next generation, including population health, dynamic strategy and social justice, to name a few. As some roles grow in importance and others emerge, it may be time for healthcare executives to reconsider the qualities and team dynamics that make for a successful workforce.

Core competencies to recruit and retain talent have traditionally included business, healthcare and, more recently within roles, specialized skills such as medical informatics, or external-facing attributes such as consumer-facing knowledge and skills. Yet, to build strong, resilient and resourceful organizations, we may need to be more differentiating in talent considerations. That means screening candidates who can withstand crises with agility, fortitude, interprofessional skills and problem-solving abilities, which will be an imperative for the future.

Many of us as leaders already consider soft skills, such as collaboration and conflict-management, when developing teams. Indeed, the healthcare field has always been emotionally complex, and as our challenges of the past two-plus years—the pandemic, workforce shortages, lagging health equity—have demonstrated, those intricacies are likely to increase. For leaders, alongside that complexity is an urgent awareness that our workforce will be the differentiator of whether we can deliver on the promise of care for all.

As such, we must carefully evaluate and prioritize added dimensions of success that, while not new, have perhaps been reshuffled to the top of the deck. Areas such as self-awareness, stress management, agility and empathy may now be the defining success factors. Riding alongside these attributes is the necessity for leaders to inspire and motivate others, to listen and learn, to guide and coach so every person can thrive even in the most adverse of circumstances.

Prioritizing workforce competencies (i.e., knowledge, skills and abilities) and communicating them to all staff has the potential to inspire and open a variety of career paths that help people understand how to enhance and develop themselves. Providing growth opportunities has also been shown to improve retention, particularly for those in clinical roles.

Leading a workforce requires a careful recipe of all these factors, balanced to bring out the best in each of us for the collective good. Most importantly, it requires attention and investment for the short term and the longer term, with a focus on building strong and resilient teams.

Much has been written about our field's workforce challenges, and these accounts are all too real. Despite all the statistics, I am optimistic about what leaders can do. Yes, innovation and new thinking will be necessary. Yet what we do right now, today, to strengthen our workforce holds the power to shape and define that pathway to the future. People are at the center of all we do, and how we respect that privilege will likely be the most defining legacy any leader leaves behind. Let us embrace this opportunity to strengthen ourselves, our teams and our organizations— for the benefit of patients and communities. ▲

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

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The
Digital Outlook

Examining Tech Advancements

by Susan Birk

In March 2020, the technology that for years had been barely

bubbling on healthcare's back burner abruptly came to a full boil, winning widespread approval among consumers and clinicians and becoming, seemingly overnight, a safe, convenient alternative for selected patients and services.

The large-scale implementation of technology for virtual visits ended up accelerating the digitization of healthcare and the demand for it among patients.

Many organizations have gone on to roll out a remarkable array of digital resources that offer convenience, enhance quality and improve patients' lives. This article profiles three of them, all leaders in digital innovation.

Catch-Up Needed

Still, despite pockets of excellence, healthcare trails other sectors in the implementation of a digital future: An October 2021 study of health systems by the Deloitte Center for Health Solutions and the Scottsdale Institute found that 20% of respondents were still in the planning stages of a digital transformation and that 40% did not have a well-defined strategy.

Similarly, the *2022 State of Healthcare Report* by the Health Information Management Systems Society found that 80% of healthcare executives who responded had begun to adopt digital solutions but that 79% were still in the planning stages of a digital transformation.

"Healthcare executives understand the criticality of digital transformation, but knowing what to implement and how to implement it is a different story," says Julie Campbell, vice president of Healthbox, a HIMSS subsidiary that advises healthcare

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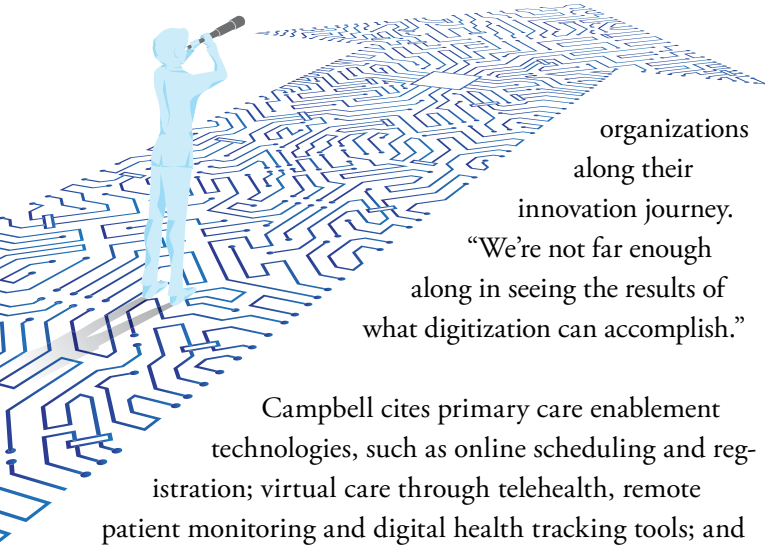
organizations along their innovation journey. "We're not far enough along in seeing the results of what digitization can accomplish."

Campbell cites primary care enablement technologies, such as online scheduling and registration; virtual care through telehealth, remote patient monitoring and digital health tracking tools; and operational enablement technologies supporting revenue cycle, supply chain and care access functions as the top three areas of adoption among providers, now and for the next five years.

"What we still need to see is insights from these technologies used in a seamless fashion," Campbell says. "We've only begun to realize what we're capable of in terms of innovation around technologies such as hospital at home, personalized medicine, and artificial intelligence and machine learning to support care quality," she says.

Build an Ecosystem
What can providers do to make faster, smarter progress? Because budgets and personnel in healthcare are typically tight, organizations can start by determining how to put the right people and financial resources behind the initiatives that will have the most impact, Campbell says.

> **"We've only begun to realize what we're capable of in terms of innovation around technologies such as hospital at home, personalized medicine, and artificial intelligence and machine learning to support care quality."**
>
> —Julie Campbell
> Healthbox HIMSS

The first step is to evaluate the organization's current state with a comprehensive self-assessment that goes beyond a mere inventory of existing systems and who is doing what.

"You need to understand what a mature digital health ecosystem looks like scaled for your organization, and then evaluate yourself against it," Campbell says. "That ecosystem will consist of many parts working together to prioritize population health outcomes informed by robust analytics that can be tracked in real time."

The goal is to know where the organization is today, set benchmarks against other organizations that are best in class and measure progress over time. "It's important to marry that against your strategic objectives and develop a road map to figure out what comes next," Campbell says.

Start With the Enterprise
Campbell stresses the importance of digital health transformation being embraced at the enterprise level. Only 43% of health systems in the HIMSS *State of Healthcare Report* had enterprisewide digital health governance. Many of these were larger systems.

"As a result, we're seeing a lot of smaller systems fall prey to digital health being done in a single functional area, like marketing or IT," she says. "That approach prescribes barriers around what can be accomplished. You've got to think through all aspects of the patient journey and involve marketing, IT, sales, innovation and other critical areas."

Another pitfall involves equating a specific digital initiative, such as an EHR or telehealth implementation, with a digital strategy. "If you're only focused on small parts of the process, you're missing out on new businesses, markets and the potential to create a transformative experience for patients and providers," Campbell says.

Though organizations are eager to maintain the pace of innovation achieved during the pandemic, Campbell encourages providers to pause and revisit these initiatives to optimize them. "For example, we

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Reference: 1. Green BB, Wang CY, Anderson ML, et al. An automated intervention with stepped increases in support to increase uptake of colorectal cancer screening: a randomized trial. *Ann Intern Med.* 2013;158(5, pt 1):301-311.

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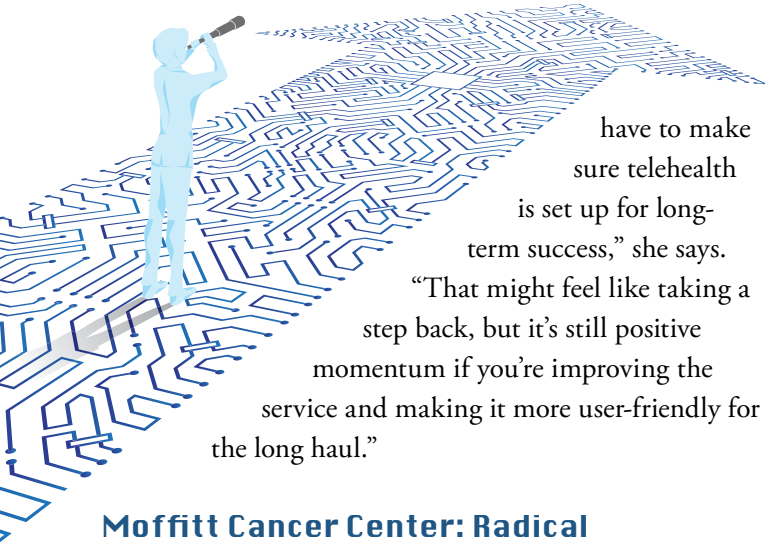
have to make sure telehealth is set up for long-term success," she says. "That might feel like taking a step back, but it's still positive momentum if you're improving the service and making it more user-friendly for the long haul."

Moffitt Cancer Center: Radical Interdependence

Moffitt Cancer Center, Tampa, Fla., is Campbell's maxim about the embrace of enterprisewide transformation come to life. Indeed, the purpose of Moffitt's Center for Digital Health and the organization's mission to prevent and cure cancer are the same.

"Our job is to leverage digital tools and technology in the service of that mission," says Edmondo Robinson, MD, chief digital officer and an ACHE Member. "Our job is to make it go faster."

In a world of many choices, boundless need and limited resources, the CDH routinely makes tough decisions about how to prioritize its investments in Florida's only National Cancer Center-designated comprehensive cancer center.

So that those decisions don't happen in a vacuum, the CDH works alongside Moffitt's other key business teams

"Just because we have a digital innovation department doesn't mean the other departments don't innovate. Everyone innovates, because if we don't, we'll fall behind."

—Edmondo Robinson, MD
Moffitt Cancer Center

on an executive governance body helmed by its chief strategy officer.

While major decisions flow from this tight collaboration at the top, the CDH also has its own governance framework for setting priorities internally. "Then we sell the rest of the organization on our projects and ideas," Robinson says.

The CDH evaluates projects according to how well they support the organization's priorities and their ability to generate return on investment—measured by gains in quality, safety, outcomes and research as well as financial returns. "We don't start with a technology solution, we start with the problem and then figure out the best tools to solve it," he says.

The CDH also illustrates Campbell's notion about digital innovation touching every aspect of the patient journey.

The work spans four buckets: 1) business operations (for example, robotic process automation); 2) clinical care (AI-enabled virtual scribes for physicians); 3) consumer engagement (an algorithm that dives deeply into matching patients with clinical cancer trials); and 4) research (virtual reality interventions that support clinical outcomes).

Three departments—IT, health data services and digital innovation—share a philosophy Robinson calls radical interdependence. "Just because we have a digital innovation department doesn't mean the other departments don't innovate. Everyone innovates, because if we don't, we'll fall behind," he says.

For example, while IT might pilot a novel chat bot to support the IT service desk, introducing that technology to other business areas such as HR would be digital innovation's job. "The innovation team learns about the innovation and is responsible for scaling it across the organization," he says.

Robinson departs from many of his peers in his belief that it should be the digital leader who articulates strategy for the organization's technology assets. At Moffitt, the CIO reports to Robinson, with IT serving

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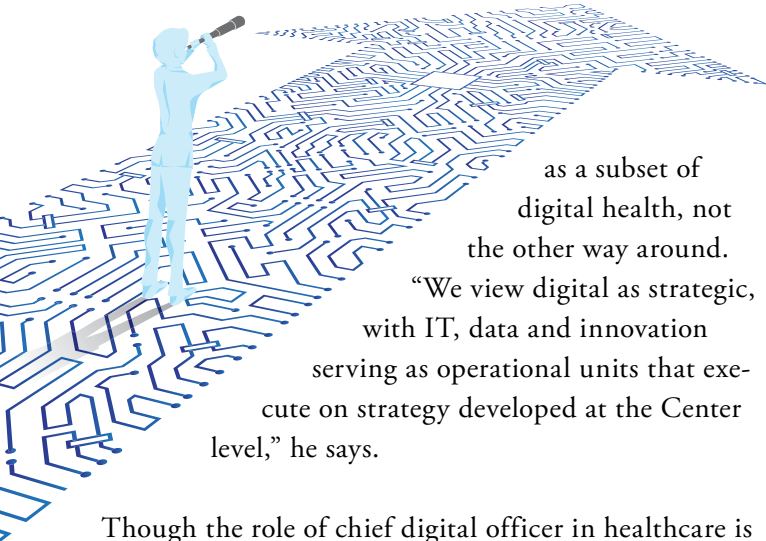
as a subset of digital health, not the other way around. "We view digital as strategic, with IT, data and innovation serving as operational units that execute on strategy developed at the Center level," he says.

Though the role of chief digital officer in healthcare is still evolving, Robinson believes a standard set of responsibilities will gradually coalesce for the role, as it did for the CIO. "Digital is here to stay. Don't just accept it, embrace it. It could be a differentiator," he advises.

In partnering with digital health companies, Robinson urges executives to stay disciplined about demanding tools and interventions backed by rigorous evidence that weeds out bias. "Digital health companies often produce flashy products with little to no peer-reviewed evidence base and minimal understanding of the impact of bias and healthcare disparities on digital health interventions," he says. "Health system leaders should hold digital health companies accountable for the quality of their solutions, as this will ultimately impact the people and communities we serve."

Houston Methodist: A Hub for the Digitally Obsessed

Like Moffitt Cancer Center, digital health innovation at Houston Methodist, part of the Texas Medical Center, doesn't happen in a silo; it's central to the organization's culture of innovation—an ethos that encourages individuals and teams to generate creative ideas as a way of working.

The Center for Innovation, the nucleus where all things digital get their start, is the centerpiece of the organization's Innovation Network, involving areas as far-flung as global operations, finance and clinical care in promoting growth through digital technology.

The Center for Innovation runs a Technology Hub, a wired physical space where tech-vendor partners work with clinicians and IT professionals to test out, train on and fine-tune solutions. Some technologies go directly to a specific unit or floor for piloting.

A steering committee representing disciplines across the innovation network dubbed DIOP, or digital innovation-obsessed people, guides key decisions. "They vet the technology, review the competitive landscape and tell us which solution stands out," says Roberta L. Schwartz, PhD, FACHE, executive vice president and chief innovation officer.

Regardless of the problem, "we always ask: Will that technology improve the work we do for patients and the people who care for them?" she says.

Recent introductions include automated care pathways that send timely text reminders and education to surgery patients. For example, based on input from surgical staff that nearly every patient will ask a week after surgery about whether they can drive, a message about driving is delivered to patients six days post-procedure.

"Our experience with using care pathways is that 85% of patients are engaging with texts that we are sending," Schwartz reports. "They say they feel like a support service is wrapped around them." By reducing phone calls, the messaging frees staff to focus on more complex patient concerns.

Houston Methodist is also harnessing the power of big data to drive clinical quality. A study comparing patient data for a clinical service for specific procedures and populations with a twinned Medicare population showed unexpectedly higher mortality rates 30 days post-discharge, prompting refinements in monitoring protocols. The organization also partnered with the Health Data Analytics Institute on an initiative that reduced code blues in the ICU by 20%.

Other efforts include expanded virtual ICU access across eight of Houston Methodist's community hospitals as well as its flagship academic medical center; virtual platforms for stroke, neurology, psychiatry and infectious disease;

and plans to bring virtual nursing capabilities to selected units, including vital sign monitoring and other services, to streamline workloads.

"We aim to bring disruption to the way we've done business," Schwartz says. "How can we make healthcare akin to consumer experiences with the major online platforms? How can we simplify healthcare to that level?"

The Froedtert & Medical College of Wisconsin Health Network: A Technology Company That Delivers Healthcare?

Digital therapeutics to empower patients and streamline care delivery and digital consumer engagement leveraging the deep functionality of a home-grown platform are the current cornerstones of digital innovation at the Froedtert & Medical College of Wisconsin Health Network, Milwaukee.

An early adopter, Froedtert & MCW began its foray into digital therapeutics six years ago with the introduction of a digital behavioral health tool in response to the shortage of mental health professionals. "Patients were waiting so long for an appointment that we felt they needed another option," says Mike Anderes, FACHE, chief digital officer.

The health system's digital therapeutics service now offers patients access to a suite of digital care programs in 46 clinical areas, including diabetes and COVID-19, all designed to help patients better manage their conditions at home.

The model doesn't remove human connection, Anderes emphasizes; in fact, care teams engage regularly with

These outpatient (top photo) and inpatient (bottom photo) rooms of the future are part of Houston Methodist's Technology Hub.
Photos courtesy of Houston Methodist.

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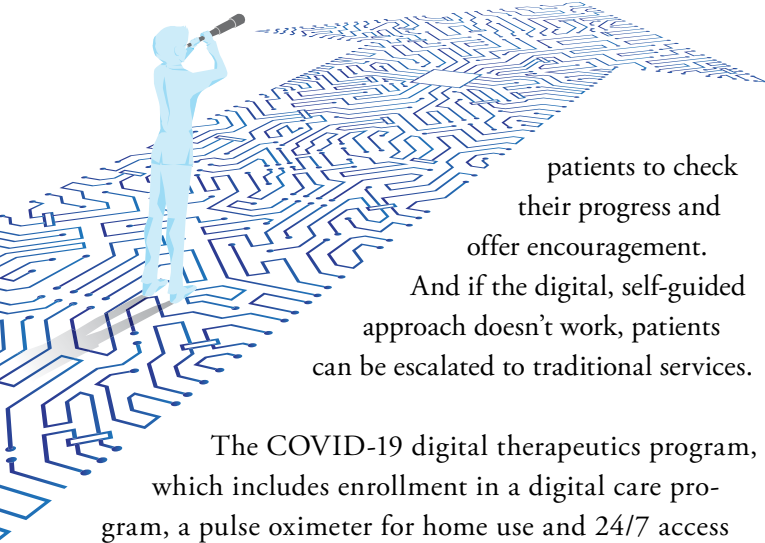
patients to check their progress and offer encouragement. And if the digital, self-guided approach doesn't work, patients can be escalated to traditional services.

The COVID-19 digital therapeutics program, which includes enrollment in a digital care program, a pulse oximeter for home use and 24/7 access to a remote care team, lowered mortality rates and reduced hospitalizations by 30%, Anderes reports. The outcomes of this program were recently published in *JAMA Open*.

To keep patients and potential patients engaged, the Froedtert & MCW mobile app ("Manage your care from your couch") simplifies and personalizes the experiences of determining what care is needed, finding and booking care, and engaging with the care team over the long term.

In a departure from the predominant practice among providers of purchasing third-party digital health solutions, the health system's subsidiary, Inception Health, handles the design, engineering and operation of the app and its associated cloud platform. Originally organized to drive digital transformation seven years ago,

the subsidiary was designed to be nimbler in service of Froedtert & MCW's strategic goals.

"Our approach is unusual in the industry, but we feel the best way to create a deeply personal experience for patients is to own key parts of technology by building it ourselves," says Anderes, who also serves as Inception Health's president.

The app is a first step in Froedtert & MCW's strategy to provide a more deeply personal approach to healthcare.

In developing digital solutions, "You have to understand the consumer, but you also have to understand the clinician because you can't add one more rock to their backpacks at this point," Anderes says. "Unfortunately, technology in healthcare has not delivered on clinician experience yet."

Froedtert & MCW is also something of a trailblazer in how it defines itself. "A question we've asked internally is 'are we a healthcare company that uses technology or are we a technology company that delivers healthcare?'" Anderes says. "We believe in the mindset that we need to be more like a technology company that delivers healthcare. Which camp organizations fall into is becoming an important differentiator."

Anderes observes how other industries have been transformed by companies that saw themselves as technology firms rather than as companies that used technology in entertainment, banking or other sectors. He says healthcare is moving in a similar direction.

Anderes calls on health systems to think more about being partners rather than competitors. "The field's real competitors are the retailers, payers and technology companies who are new entrants to the competitive landscape," he says. "If health systems band together, we'll be more successful in the digital world."

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

"We aim to bring disruption to the way we've done business. How can we make healthcare akin to consumer experiences with the major online platforms? How can we simplify healthcare to that level?"

—Roberta L. Schwartz, PhD, FACHE
Houston Methodist

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Northern Light Health's optimization journey leads to improved care quality, patient experience.

"When we maximize our EHR … it produces a product that will assist in equitable quality care for our patients and delivery of an excellent patient experience."

—James Douglas, DO
Regional Medical Informatics Officer, Mid-Maine Region and Mercy Hospital/Co-Chair, Clinical Stakeholder Group
Northern Light Health
Brewer, Maine

Leaders at Northern Light Health, Brewer, Maine, know that to continually improve patient outcomes, the 10-hospital, fully integrated health system must squeeze every ounce of efficiency out of its EHR system.

"When we maximize our EHR, there are revenue cycle gains, there's an increase in end-user satisfaction and, most importantly, it produces a product that will assist in equitable quality care for our patients and delivery of an excellent patient experience," says James Douglas, DO, regional medical informatics officer, Mid-Maine Region and Mercy Hospital, and co-chair, Clinical Stakeholder Group, Northern Light Health.

Validation of the organization's success is seen not only in its delivery of care but also in other ways. Northern Light Health has reached Stage 7 on the HIMSS Outpatient Electronic Medical Record Adoption Model. Participation is a sign of an organization's commitment to excellence.

The health system has undertaken numerous EHR optimization initiatives such as focusing on ease of use for consumers and closing gaps in care, which improves outcomes, according to April Giard, DNP, APN, NEA-BC, senior vice president and chief digital officer. Northern Light Health also aims to bolster clinician efficiency and reduce clinician and staff cognitive burden, including decreasing "alert fatigue."

"We have found that better patient outcomes often are directly tied to a better clinician experience," Giard says. "After eliminating certain alerts in the EHR, we reduced medical errors and, at the same time, decreased cognitive burden for our clinicians."

Being what Giard and Douglas describe as a "clinically led organization" has meant all the health system's EHR optimization efforts and strategic plans have buy-in from clinicians. Douglas co-chairs a clinical stakeholder group comprising representatives from across the health system, which provides governance and guides the effectiveness of technology services and solutions.

Following are examples of the EHR optimization initiatives that aim to deliver optimal outcomes and excellent patient and clinician experience at Northern Light Health.

Making mammograms more convenient. One current initiative is a streamlined process for online routine mammogram scheduling. Patients can pick times convenient for them and complete registration intake questions beforehand rather

than in the provider's waiting room. Answers to the patient's questions appear directly in the Cerner EHR platform for immediate review by clinicians. A hands-free check-in process offers another convenience: After completion, patients receive a QR code on their smartphones, which can be scanned when they enter the provider's office, allowing them to bypass waiting in line at the front desk.

"Overall, these initiatives will help increase access to women's healthcare," Douglas says.

Improving blood pressure control. This project identified EHR optimizations and new tools to alert clinicians to patients with high blood pressure. A newly created "smart zone" alert can be viewed by medical assistants or clinicians upon opening a patient's chart. The alert reminds clinicians to repeat the blood pressure test during the appointment if needed and to make sure high blood pressure is addressed.

Patients also can track and document home blood pressure readings in a patient portal. This can help capture more accurate blood pressure information for patients with "white coat syndrome" or other stress-related factors that can result in higher readings in the doctor's office versus at home. These initiatives have resulted in an increase of blood pressure control from 73% to 75% in five months, according to Douglas.

Optimizing a vaccine rollout. Being able to innovate and add new tools within its EHR also proved essential to the health system's COVID-19 response. "Our response was extensive and required significant optimizations within our EHR," Douglas says.

Working with Oracle Cerner, Northern Light Health built a mass vaccination tool. Using barcode scanning technology, the health system records all vaccinations on a vaccine report

in the EHR, which is then shared directly with Maine's immunization information system.

"The tool was so efficient our patients would complete their immunization process within 30 minutes, including the 15-minute wait time," Douglas says. "It was critical to the seamless rollout of our mass vaccination sites, and our process was viewed as a model for the state."

Setting the Standard
Achieving Stage 7 O-EMRAM status has set the standard the team at Northern Light Health continues to hold itself to as it looks to expand existing initiatives and develop new ones.

"I know there's not a HIMSS level eight, but it's important to keep in mind that we are at level seven," Douglas says. "We continue to expand on the work we've already done, and we expect the quality of what we're producing to be at that level. We're holding ourselves to that."

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True
Intelligence
Where AI Is Working Today

By Karen Wagner

Intermountain Healthcare Chief Digital and Information Officer Craig Richardville does not believe the term "artificial intelligence" is appropriate. He prefers advanced intelligence. "Because artificial means fake, right?" he comments. "And it's not fake. It's true intelligence."

Indeed, it is true intelligence that in the midst of high burnout rates and staffing shortages, along with increasingly complex care, is enabling healthcare organizations like Intermountain to improve care management, quicken diagnoses and streamline clinician workflow.

Yet, as healthcare leaders better understand how artificial intelligence is addressing today's clinical, operational and financial challenges, they are also recognizing limitations of its use as they weigh employing artificial intelligence in their hospitals and health systems.

AI in Clinical Use

Salt Lake City-based Intermountain Healthcare is using such intelligence to record patient encounters, interpret those conversations and automatically produce clinical documentation. In addition to improving clinical workflow, the tool can be more accurate than a clinician relying on his or her memory. This advantage then can result in more accurate coding for documenting conditions and billing services, Richardville says.

"So, you have a more accurate outcome that's being produced, and you have a more accurate record of the work done during the visit," he says.

True Intelligence
Where AI Is Working Today

> "" **Things like AI-driven virtual care assistants are the next frontier for patient engagement.**
>
> —Julius Bogdan, HIMSS

One of the applications in which AI has advanced most quickly is diagnostics, such as interpreting mammograms and MRI, CT and retinal scans, says Don A. Goldmann, MD, chief scientific officer emeritus and senior fellow with the Institute for Healthcare Improvement, Boston.

AI use is also demonstrating its value in melanoma detection, in which remotely captured images of lesions can be interpreted just as, or sometimes more, effectively than by a dermatologist, he says. Enhanced virtual melanoma detection has catalyzed a focus on equity, as the initial algorithms did not account well enough for the appearance of lesions on dark-skinned patients. This realization, in turn, has led to a new emphasis in dermatology training on recognizing dangerous lesions on people of color.

Novant Health, a 15-hospital system based in Winston-Salem, N.C., uses AI in the ED for quicker diagnosing of emergent patients. On a busy night, there can be 50 to 100 radiology images needing to be read, says Eric Eskioglu, MD, the health system's chief medical and scientific officer and an ACHE Member.

"This AI algorithm scrubs the images and automatically prioritizes the images that have the abnormal findings to the top of the radiologist's queue," Eskioglu explains. "And, within that queue, it reprioritizes the most emergent that have to be read first."

The tool helps physicians make faster diagnoses and leads to turnaround times that are five to 10 minutes shorter for more emergent patients, he says, adding that it has increased physician satisfaction with reduced anxiety.

The Central Virginia healthcare system of the Department of Veterans Affairs recently implemented a device that leverages AI during colonoscopies to help recognize and diagnose cancer growth, says Gil Alterovitz, PhD, FACMI, director of the National Artificial Intelligence Institute for the VA, the nation's largest healthcare system, which facilitates the use of AI across its medical centers.

McGuire VA Medical Center in Richmond, Va., became the first hospital in the United States to purchase and incorporate the intelligent endoscopy; the technology is now available to other VA centers. The tool provides an auditory and visual alert to the endoscopist to take a second look in a particular area of the colon that the physician may have missed, Alterovitz explains, describing the technology as a kind of second opinion for physicians.

"It is enabling the physician to have another set of eyes looking at the same image that they are looking at," he says.

Artificial intelligence has grown rapidly in many areas, including diagnostic imaging, population health management and remote patient monitoring applications, says Julius Bogdan, vice president of analytics for Chicago-based HIMSS (Healthcare Information and Management Systems Society) and an ACHE Member.

"Things like AI-driven virtual care assistants are the next frontier for patient engagement," he says, referring to technology that interacts with patients, helping them understand their healthcare journey and better manage their care. "The more insight we can put in the

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—Gil Alterovitz, PhD, FACMI, National Artificial Intelligence Institute, Department of Veterans Affairs

patients' hands to manage their health and wellness, the better off their health outcomes are going to be."

The VA is also piloting the use of AI in remote patient monitoring for chronic disease management. Sensors are used to record the patient's medical condition and send it to the AI tool, Alterovitz says.

"If there is something to flag, the AI can call it to the attention of the doctor and the patient at specific times," he says.

Goldmann believes that AI will be used more frequently in primary care patient encounters to predict the need for customized or specialized care. For example, many providers now routinely use AI analytics to calculate risk scores for a cardiovascular event. These scores then can be used to inform conversation with patients about ways they can reduce their personal risk. Similar analytics can help predict which patients with heart failure are at risk for hospitalization so timely interventions can be implemented.

What About the Workforce?

Alterovitz' description of AI as a "second opinion" echoes the sentiments of others regarding its use as a support tool that aides clinicians in diagnosing and workflow.

"AI will not replace physicians, but physicians who do not use AI will be replaced, as either one by itself is less than

optimal. It takes both, the combination of the machine and the provider, to achieve the best optimal outcome," Richardville contends.

Intermountain Healthcare's ambient intelligence tool, which is in the early adopter stage and used by between 100 and 150 physicians at the 33-hospital system, is offered as an option. The feedback from these early adopters has been very positive, Richardville says, noting that physicians have reported an improved work-life balance.

In addition to improving safety through more accurate documentation, the tool can help reduce physician burnout by alleviating administrative burden, allowing providers more free time. Richardville says during pilot testing of the tool, some providers saved about 1.5 hours per day by not having to dictate notes and instead reviewing notes produced by the AI. "That is a big savings," he says. "We've seen huge satisfaction ratios."

"What I foresee is physicians who use AI are going to be so much more effective and precise and be able to spend more time with their patients, and they will be the ones who will replace physicians who resist AI," adds Novant Health's Eskioglu.

By supporting clinical decision-making for more routine diagnoses, AI can enable clinicians to more effectively work at the top of their license, freeing up their time from some of the more foundational elements of care, Bogdan says.

He adds that AI can help remove or minimize time spent on tasks, which Bogdan says accounts for about 10% of a health practitioner's time, allowing more time for direct clinical care.

"There's a growing demand for healthcare, and that's not going away. AI can't solve for that, but it can help expand capacity," he says.

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> **"AI will not replace physicians, but physicians who do not use AI will be replaced.**
>
> —Craig Richardville, Intermountain Healthcare

The Other Side of AI

Despite the advances that AI brings to the healthcare space, the technology does have limitations, data insufficiency being a significant one.

To be useful, data should be reliable, high quality and accessible, and that's not always the case, Bogdan says. Data siloes, caused by IT systems that cannot share information either within a health system or across disparate systems, continue to be prevalent in healthcare, limiting AI's functionality.

Eskioglu says physicians are spending greater amounts of time each year on research, gathering data and keeping up with trends—work that is more suitable for AI. No human mind can keep up with the amount of medical information, which is growing exponentially in shorter periods of time.

"It is estimated that the doubling time of medical knowledge in 1950 was 50 years; in 1980, 7 years; and in 2010, 3.5 years," Eskioglu says. "In 2020, it is projected to be 0.2 years—just 73 days. Students who began medical school in the autumn of 2010 will experience approximately three doublings in knowledge by the time they complete the minimum length of training (7 years) needed to practice medicine. There's no way a human mind will be able to keep up with that and be able to see a patient and be effective."

Alterovitz concurs, adding, "It will not replace the workforce, but rather enable more focus on specific areas that require more human touch, so to speak. That is the thinking around how the AI will improve the workforce going forward."

What to Consider in AI Use

The following factors are vital when considering the use of artificial intelligence solutions:

Patient safety/quality. "With every AI project, we put on a safety and quality lens to see if it will improve the safety of our patients and the quality of their outcomes," says Eric Eskioglu, MD, chief medical and scientific officer for Novant Health.

An important component of any AI initiative is choosing a champion; someone who can define the problem and work closely with the technology finance team to determine how the solution could positively impact safety, as well as support value-based care through higher-quality care and cost efficiencies, Eskioglu says.

Strategic alignment. Artificial intelligence is not a catchall solution, says Julius Bogdan, vice president of analytics for HIMSS. Instead, determining where AI can be best used is a more

"It's what you feed into that algorithm that determines the results," he says. "There's a data bias problem across AI in multiple industries, but in healthcare in particular, because we have limited and disparate data sets."

Equity is often a major challenge with some data sets. The data may be biased toward a specific population, rather than being inclusive of all populations that a hospital serves.

"The kind of data and the voices of patients that are in AI today by and large are skewed to the people who engage with the healthcare system in certain ways and skewed against some people who for a whole variety of structural and personal reasons may not be engaged, willing or able to provide data about their experience," Goldmann says. "So, anybody thinking about AI has to constantly bear these critical potential biases in mind."

Goldmann points to examples within specific populations. The decision whether to perform a vaginal birth after a prior cesarean has anthropomorphic inaccuracies that effective approach. "AI should align with the strategic initiatives of the healthcare organization, whether that's improving financial sustainability or improving metrics on population health, such as reducing diabetes in a population," he says.

He adds that AI implementation should start small. "Take the lessons learned and then grow into tackling bigger challenges," Bogdan says. "Think key critical areas that are aligned with strategy that AI can help with."

Stakeholder involvement. "Incorporating a cross-collaborative approach across operations, quality and safety, and clinical is the best way that I've found to help drive adoption," Bogdan says. When a use case is identified for AI, Bogdan says it should be an enterprisewide project that incorporates all these areas.

Transparency. AI works best when initiatives are "unwrapped" and in the open. Adoption is driven when clinicians are educated on AI's function and how algorithms work.

"It really helps if the system is understandable by the practitioner. That is especially true with new technologies," says Gil Alterovitz, PhD, FACMI, director of the National Artificial Intelligence Institute.

AI culture. Eskioglu says he has an open-door policy to work with any clinician—physicians, nurses, pharmacists, pharmacy technicians, nurse aides—who has an idea for how to use AI to improve their roles. He says it is important to create a culture in which caregivers are not intimidated by these solutions but willing to embrace them and frame the problems that AI can address.

Reputation. Artificial intelligence should have practical applications that offer clear benefits, says Don Goldmann, MD, chief scientific officer emeritus and senior fellow for the Institute for Healthcare Improvement. "There are a lot of claims being made, a lot of really great research. The questions I always ask are 'Is it ready for general use?' 'Will it be accepted by clinicians and patients?' and 'Can it be efficiently and equitably integrated into the work that's already being done?'"

> ## " What I foresee is physicians who use AI are going to be so much more effective and precise and be able to spend more time with their patients.

—Eric Eskioglu, MD, Novant Health

discriminate against Black women, he says. Pulmonary function tests that have thresholds based on lung function analytics are discriminatory against Black people with lung disease. "You don't have to look hard to find examples of built-in inequities in guidelines. Some of these findings are being addressed aggressively, such as renal function algorithms that disadvantage Black individuals who are being considered for dialysis or transplantation," Goldmann says.

Providers can account for these potential biases by being aware of them. In particular, when considering the output of AI decision support, a provider in an office visit with a patient should consider the patient's background, including both their social situation and genetic predisposition. Goldmann says if he had an algorithm based on data mining to predict whether his patient's chronic abdominal pain is ulcerative colitis or Crohn's disease, he would want to know if that patient were of Eastern European or Jewish decent, noting populations in which the disease is more common. He also would want to know the social circumstances that might be important in creating a differential diagnosis, customizing care, and ensuring easy access to treatment and follow-up.

Similarly, when calculating a patient's cardiovascular risk, it would be good to know if the patient was living with

housing insecurity, gun violence or other stressors. Such characteristics might influence the patient's risk of high blood pressure, Goldmann says.

Understanding the distribution of your data will alert you to bias, Bogdan says. Data that is based on a population that is majority white, for example, will be biased toward that population.

One way to control the bias is by augmenting the data with other data sources, Bogdan says.

"There's a multitude of methods to address bias," he says. "First and foremost is understanding that your data is biased."

Governance is another issue. Though there appears to be a consensus that AI serves as decision support in healthcare, what happens if there is a misdiagnosis in a case in which AI was employed? Who is responsible? These are significant questions that have yet to be answered, Bogdan says.

"There's still a lot of work that needs to be done on the governance front," he says.

The Human Element

As AI is increasingly implemented in healthcare, there will continue to be a melding of the best of human intelligence and machine intelligence. It is a combination of the art of the human element and the enhanced precision of the technology that will advance medicine and healthcare, Richardville says.

"The human element and the AI element need to follow in together," he says. "Either one by itself is not as good as both working together."

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

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Using Data to Drive Laboratory Stewardship Initiatives

Real-time insights key to identifying opportunities for clinical and financial improvement.

"It's in everyone's best interest to promote appropriate test utilization, especially as the industry moves toward a value-based care future."

—Rachael Hulshizer
Manager, Clinical Products and Services,
Value-Based Medicine
Mayo Collaborative Services
Rochester, Minn.

Here's some good news in today's financially challenging healthcare environment: Opportunities exist for decreasing inappropriate laboratory ordering and unnecessary lab spend. Provider organizations just need to know where to look.

Approximately 7.7% of all lab orders are clinically inappropriate, which renders about 12% of lab spend unnecessary, according to *The Change Healthcare 2021 Laboratory Ordering Utilization Index*. The report, which draws insights from Change Healthcare's CareSelect Lab point-of-order decision support solution, found that opportunities for reducing inappropriate ordering and lowering costs can be found across the entire spectrum of testing, from genetics tests to daily, routine labs.

Identifying such opportunities is beneficial for numerous reasons. "Inappropriate testing can waste patient time and, in some situations, add time to diagnosis and length of stay," says Caroline Juarez, product owner and manager, CareSelect Lab, Change Healthcare, Lafayette, Colo. "Inappropriate lab ordering also can increase the number of patient blood draws in inpatient and outpatient care settings and can lead to potentially unnecessary repeat outpatient visits."

Increasingly cost-conscious patients and overall financial pressures on hospitals due to decreased reimbursements from the pandemic round out some of the other reasons why good lab stewardship is rising in priority for healthcare leaders.

"While lab is typically a relatively small portion of a health system's budget, many clinical decisions are based on lab tests, so inappropriate orders and unnecessary tests can quickly lead to more tests and more visits, which can increase total cost of care," says Rachael Hulshizer, manager, clinical products and services, Value-Based Medicine, Mayo Collaborative Services, Rochester, Minn. In fact, according to the Change Healthcare utilization index, consistently placed inappropriate orders (those placed inappropriately more than 90% of the time) drive more than 45% of unnecessary spend.

Using a data-driven approach, Mayo Clinic has reduced unnecessary testing and improved overall laboratory stewardship.

From Insights to Action

One challenge for Mayo Clinic was identifying issues within its lab stewardship program, quantifying those issues and understanding how to fix them, according to Hulshizer. Via dashboards that monitor ordering, the CareSelect Lab solution provides those insights, illuminating challenges and helping to guide next steps.

"Organizations can use the data to determine how they would like to take action, whether it's education efforts, updates to their EHRs or point-of-order guidance to clinicians, for example," Juarez says.

The ability to create custom content within CareSelect Lab helps organizations identify specific areas in which to improve

test-ordering practices. "For example, if there is a one-day frequency rule in place for lab ordering, we can change it to a two-day frequency rule and see how that data looks," Hulshizer says.

Insights from CareSelect Lab also help Mayo Clinic understand variations among its multiple practices. "The Mayo Clinic Rochester is very different than our practices in Arizona and Florida, and the Mayo Clinic Health System practice differs from the other three," Hulshizer says. "We can now understand variations among our four groups."

Overall, the solution assists with systemwide collaboration. "We can give people within our institution access, and the data in the platform allows us—a small group of laboratorians who support the Mayo Clinic enterprise in its lab stewardship journey—to interact with other internal groups that were not aware of us previously," Hulshizer says. "Now we are better able to help drive change."

For example, working with clinicians and other staff on Mayo Clinic's lab stewardship committee, Hulshizer's team used the data from CareSelect Lab to determine ways to improve the health system's utilization of standard metabolic panels for inpatients. Rather than reordering the larger comprehensive metabolic panel, the team decided to move forward with recommending smaller panels based on the analytes of interest only, as the data shows it will result in significant savings.

Integration with a healthcare organization's EHR system makes improvements like this possible. "CareSelect Lab is integrated directly into an organization's order-entry workflow and EHR, so it uses key inputs like prior lab results and diagnoses to determine the appropriateness of the test being ordered," Juarez says. "The solution runs in the background with no change to the ordering clinician's workflow."

CareSelect Lab is bolstered by clinical appropriateness criteria that Mayo Clinic subject matter experts author and update, making the health system not only a customer but also a partner in developing and maintaining the solution. The data is revised regularly, providing organizations with access to the latest clinical appropriateness data. Lab stewardship programs can be tweaked accordingly to benefit patients and the organizations' financial health.

"It's in everyone's best interest to promote appropriate test utilization, especially as the industry moves toward a value-based care future," Hulshizer says. "Now is the time to invest so you are ready for that future, because at the end of the day for lab stewardship, your focus is on good patient care, and the financial impact will follow from that."

For more information, please visit inspire.changehealthcare.com/CareSelectLab-Analysis or contact Jennifer Dye, strategic account executive, Clinical Decision Support, Change Healthcare, at jennifer.dye1@changehealthcare.com.

The Ethics of AI and Machine Learning

Leaders should consider these core ethical questions.

Jason Lesandrini, FACHE

The healthcare industry has always been an open frontier for innovation, and it has strongly supported using new technologies for improving quality of care and patients' overall experience.

The key to the ethical adoption of any artificial intelligence/machine learning tool is to ensure that it is being used in an ethical fashion.

Artificial intelligence and machine learning have become intimately tied with these initiatives, and use of these tools has exploded in the past 10 years across a wide range of disciplines.

For example, some health systems use AI to improve lung cancer screening, and others have used AI during the COVID-19 pandemic to triage patients and predict outcomes.

Though these tools provide numerous benefits, healthcare organizations need to consider the many ethical concerns associated with them. Numerous others have written about the main ethical issues associated with AI and ML, including big data, algorithmic biases and privacy concerns, but the ethical challenges do not stop there. To be proactive in addressing ethical challenges, it is vital that organizations have answers to core ethical questions that arise in three critical phases of AI/ML use: pre-implementation, implementation and post-implementation.

The goal of raising these questions is to embed ethical decision-making structures and behaviors into the culture of adopting these technologies.

Pre-Implementation
Before adopting an artificial intelligence or machine learning tool, undertake a comprehensive ethical reconciliation with the technology. First, develop a set of broad ethical and practical principles to guide the creation, application and evaluation of AI and ML.

In addition, include ethical questions for each principle that can be used every time an organization considers using these technologies. Examples of such principles, inspired by those proposed by the World Health Organization and similar agencies, and accompanying potential questions include:

- **Avoidance of harm**: Does the tool cause the patient harm? Or, does the tool increase burdens incurred by patients?

- **Bias reduction principle**: Is the data the tool collects propagating bias toward groups based on race, ethnicity, gender or other factors?

- **Informed decision-making principle**: Has the patient or surrogate been informed about the use of AI in their care?

- **Protect human autonomy**: Does the tool allow a provider to override the algorithm when necessary?

Second, to assist with implementing these principles, enlist the help of the ethics committee to review proposed projects in the context of the institution's broader ethical principles.

Given the increased frequency of ethics issues occurring in healthcare, consider hiring an ethicist who can provide specific guidance on these issues in addition to clinical matters.

Some key questions for ethicists or ethics committees to ask about AI/

ML tools during the pre-implementation phase include:

- What ethical tradeoffs has the organization made with using this tool, if any? If tradeoffs have been made, what justifications has the team given for prioritizing one value over another?

- What would complete ethical failure look like while using this tool?

Implementation Phase
As the technology is implemented, promptly resolve ethical issues to improve the AI/ML tool. This can be done as part of an ethics evaluation at regular intervals during the training phase of the tool and shortly after implementation. Core ethical questions to ask at this phase of the process include:

- Is misuse of the product occurring? Is there a risk of it being misused in the future?

- Are there any users who will have trouble using the product? For example, are there people with disabilities who would benefit from the use of the tool but are unable to do so because of the way it is designed?

- Have staff reviewed the data generated by the tool and determined if it exacerbates biases or creates new biases against disenfranchised populations (for example, racial groups, socioeconomic groups or others?)

To address any unforeseen ethical conflicts or uncertainties that arise during this phase, make ethics resources available for providers or whoever is implementing the tool.

Post-Implementation
As these tools continue to play an increasingly significant role in healthcare, continuous evaluation of them at regular intervals (e.g., every three months or every six months) will be critical to identifying new ethical challenges when they arise.

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Though these tools provide numerous benefits, healthcare organizations need to consider the many ethical concerns associated with them.

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An assessment will also ensure the tool continues to adhere to the organization's defined core ethical principles and that any ethics issues have been resolved. The primary ethical questions to ask at this phase include:

- Have staff members completed an evaluation of the AI/ ML tool to see that it continues to adhere to the core ethical principles?

- Has the tool exacerbated any biases or created new ethical issues that need addressing?

Consider this ethical AI occurrence: A widely used population

health algorithm tool resulted in African Americans being less likely to be referred to additional services than their Caucasian counterparts, even though they were sicker, according to an Oct. 25, 2019, article in *Science* by Ziad Obermeyer, Brian Powers, Christine Vogeli and Sendhil Mullainathan.

The bias or ethical issue was identified when it was found that the AI tool uses healthcare costs as a proxy for healthcare needs. Because less money is spent on African American patients with the same disease states as Caucasian patients, the algorithm predicted that the African Americans did not need additional resources.

The key to the ethical adoption of any artificial intelligence/machine learning tool is to ensure that it is being used in an ethical fashion. This includes an assessment from the beginning stages of development, all the way to post-implementation, when organizations evaluate use of the tool and any ethical issues that have arisen.

By being intentional about identifying the ethical challenges, addressing them and preparing to utilize them as a learning tool for future AI/ML implementations, healthcare organizations can start to see the great benefits these tools can bring to the field. ▲

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

Helping Hands

How one children's hospital is addressing the labor shortage.

Christine Young, RN,
NEA-BC

Throughout the pandemic, labor shortages have had a profound impact on businesses across the country, tightening the labor market locally, regionally and nationally. Though labor shortages currently affect many industries, healthcare staffing shortages have caused significant changes in operations and challenges for many pediatric hospitals. But at Akron Children's Hospital, where employees work in close collaboration with one another, the labor shortage instead strengthened the team through various initiatives the hospital enacted.

For pediatrics, the early days of the pandemic resulted in a significant decrease in patient volumes because the COVID-19 virus did not affect children at the rate it did adults. The hospital reassigned staff to other necessary roles, such as screening visitors and staff, serving as personal protective equipment champions, and training others for adult care in the event it became necessary to help offload the surges of patients at adult hospitals.

As the hospital saw patient volumes rise due to an unseasonal increase in respiratory illness, compounded with surges in COVID-19 cases, the staffing challenges continued to grow, and capacity was strained. Further, there was a need for staff to provide COVID-19 testing and vaccinations to support pandemic management within the hospital's workforce and community, and staff were needed to help in the hospital's continuing efforts to address the ongoing mental health crisis among children.

It's critical to get ahead of burnout by confronting and addressing it through tailored benefits, initiatives and services for employees.

How Staff Lent Their 'Helping Hands'
To immediately address the staffing shortage and ensure it did not impact the hospital's ability to deliver high-quality care, Akron Children's Hospital put in place several recruitment and retention strategies. In addition to offering bonus incentive pay programs for staff who were willing to work extra hours, as well as recruiting and rehiring retired staff or those previously employed by the hospital, Akron Children's launched its Helping Hands program in September 2021.

Helping Hands is a voluntary, paid program to deploy staff members with clinical or other skills to work extra hours addressing critical patient needs and to support care delivery at the bedside. Program participants are matched with opportunities for assignments based on current skill sets and to receive training to work across the hospital.

From a staffing perspective, to ensure resources are allocated to areas with the greatest need, assignments are made daily across the health system outside of department silos. This process gives staff members the ability to work outside of their regular duties. So far, more than 900 employees have expressed interest in being part of the program. On average, the program provides 30 full-time equivalents of supplemental staffing per pay period to various departments, with the highest utilization in behavioral health, emergency services, environmental services and nutrition services.

Addressing Medical Burnout
Prior to the pandemic, shortages of hospital workers and insufficient staffing, which spread beyond clinical staff, were ongoing issues for healthcare systems across the country due to the nation's aging population. Given the impact of the COVID-19 pandemic and the strain on staff, and with many employees quitting or retiring, hospital worker shortages represent a long-term challenge nationwide.

Recognizing that the impact of the shortage was going to last long into the future and that there was a need to provide short-term solutions to address staff needs, Akron Children's Hospital started providing services to address resiliency and well-being. The hospital launched a resiliency cart to provide food and beverages for staff

members and a meditation program to help staff achieve long-term wellness. These efforts help combat burnout, relieve stress and provide an opportunity for leadership to connect with staff.

Akron Children's also recently launched a multipronged caregiver resiliency effort, which includes retreats teaching evidence-based breathing techniques that facilitate the release of deep stress and promote overall well-being. Retreat participants saw a 16% decrease in anxiety and a 21% improvement in sleep. The hospital also started providing free psychology and psychiatry support for medical staff through a partnership with the Akron Physician Wellness Initiative. To assess the effectiveness of these initiatives, the hospital launched an online well-being assessment tool for physicians, residents/fellows, advanced practice providers and nurses. The Well-Being Index allows users to measure their own burnout over time, compare their scores to their peers, and access wellness resources nationally and within Akron Children's.

Looking to the Future
Despite the pandemic's strain on the workforce, recent upticks in nursing school enrollment may indicate a more robust long-term staffing pipeline and solution. Looking forward with proactive measures, Akron Children's is reaching the next generation of healthcare workers through additional recruitment and educational initiatives. Examples include the hospital's diversity workforce development program, Career Launch; the ASCEND—Assuring Success with a Commitment to Enhance

Nurse Diversity—program for nursing students; and its Nurse Residency program, which helps support the transition of new nurses from student to professional.

These forward-thinking efforts were expanded early this year when the hospital added an associate degree option as part of its Career Launch/Career Launch Plus workforce development program. To attract more healthcare workers, address barriers to entry and recruit more workers from diverse backgrounds, the new program pays for underrepresented students to earn an associate degree in nursing and guarantees them a position at the hospital upon graduating. Not only does this program launch individuals into their careers, it opens doors to more fields within nursing as their careers progress.

For hospitals, short- and long-term solutions are needed to address ongoing staffing issues. Workforce recruitment and retention is critical to providing a continuum of care and support for patients and staff. Equally important when discussing staffing challenges is retention and giving the right care that supports staff.

It's critical to get ahead of burnout by confronting and addressing it through tailored benefits, initiatives and services for employees. In addition, as healthcare systems continue to navigate these challenges, flexibility is critical. In some cases, this may even mean rethinking systems to better align with staff needs and preferences. ▲

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Focus on Employee Mental Wellness

Providing confidential support with digital therapeutics.

John M. Kutch

It was heartening to see some good news on the COVID-19 front this summer when coronavirus vaccines were made available to roughly 18 million children younger than five years old. Many healthcare workers, however, continue to face the mental and physical tolls of being asked to work especially long hours in unpredictable environments. As such, healthcare executives continue to rethink how to best support their patients and staff amid employee burnout and workforce shortages.

Overcoming Stigma
A survey conducted in February and March 2021 by the Kaiser Family Foundation and *The Washington Post* found that a majority of healthcare workers feel pandemic-related stress has negatively impacted their mental health, yet only 13% said they accessed mental health services. Too often, it's the stigma associated with mental illness and substance abuse that continues to keep many people—and especially healthcare professionals—from getting the help they need. In many parts of the U.S., state medical licensing laws require healthcare professionals to report all incidents of mental illness. As a result, many avoid seeking mental healthcare because they are afraid their career could be damaged or that they could lose their license to practice medicine.

Digital technologies, like digital therapeutics, offer one possible solution to these challenges. Digital therapeutics can provide discreet, confidential support for mental health issues such as depression and problematic alcohol use. They can be a valuable part of an organization's toolkit for tending to the mental health and well-being of its employees.

Digital Therapeutics: A Helpful Solution
Trinity Health, Minot, N.D., employs more than 2,800 people and provides more than 450,000 encounters annually. Like many organizations, the health system's staff experienced professional burnout and other mental health issues during the past two years, and it became increasingly clear that they needed additional support from leadership.

The leadership team recognized digital therapeutics as a unique way to provide highly scalable, program-based cognitive behavioral therapy. This aligned to the organization's goal of prioritizing accessibility without sacrificing care quality. Leaders also knew any new options had to address employee work-life balance directly and tangibly, and they wanted to address the stigma associated with mental health by speaking openly about the value that novel digital therapies could offer employees.

The health system purchased a suite of evidence-based digital therapeutics that uses cognitive behavioral therapy-based approaches and artificial intelligence. This approach helps users identify problematic thought patterns and behaviors and then supports and guides them in establishing healthier habits.

Each platform provides on-demand, 24/7 treatment and is accessible from any location with internet access.

Trinity Health offers two digital therapy platforms to staff: one that treats chronic or recurrent depression or depressive disorders and another that helps individuals address problematic drinking habits. Each platform provides on-demand, 24/7 treatment and is accessible from any location with internet access.

Much like other health systems, Trinity Health was new to digital therapeutics and wondered what made the options the organization selected different from consumer mental health apps. Leadership vetting the platforms learned one key difference is that these tools are held to the same medical and regulatory standards as traditional medical treatments. Knowing that these platforms had

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been clinically evaluated and were rooted in scientific and clinical-based evidence enabled Trinity Health to educate stakeholders on how digital therapeutics could support staff, and staff members were grateful to have an option they could trust.

Numerous employee-wellness efforts were already in place, including a strong employee assistance program. The digital therapeutics solutions complement existing programs, reinforcing the organization's priority to offer real options in support of employees' mental and physical health.

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Healthcare executives continue to rethink how to best support their patients and staff amid employee burnout and workforce shortages.

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Program Implementation
The digital therapeutics platforms are made available, free of charge, to staff and their dependents. Given the sensitivity of the space in which the organization's employees work—and the perceived risk to healthcare workers of seeking mental healthcare—leaders knew confidentiality was vital to encouraging team members to take advantage of the platforms.

Links to the platforms reside on the health system's HR website for easy access and take employees to private microsites that are unaffiliated with Trinity Health. Employees can then sign up at their own discretion outside of work hours. They also have the option, and are encouraged, to use a personal email address when creating their account. Trinity Health HR

team members have been trained on the platforms so they can confidently field questions from employees.

Insights and Takeaways
Since the organization has made the platforms available to Trinity Health employees, many have opted to try them. As part of the organization's commitment to keeping the platforms confidential, the data and insights Trinity Health can gather from the platforms are limited; however, leaders have received direct, positive feedback from employees who have benefited from the program.

These insights are helping to shape Trinity Health's strategic plans. For example, the health system is ready to consider taking this internal program one step further by offering digital therapeutics to patients, as well. Use of this readily available and capable technology could help increase provider capacity, allowing them to serve patients who need care regardless of time of day or geographic location.

Though the health system is still in the early stages of this work, it continues to understand how digital therapeutics can help not only healthcare workers but also the overall healthcare system. Becoming educated about and investing in new tools that can provide mental healthcare support for employees should be priorities for health systems today. Digital therapeutics are one way to help pave the way for a stronger, more agile healthcare system. ▲

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The 2023 Healthcare Regulatory Agenda

Next year, much of the plan will shift to state control.

Paul H. Keckley, PhD

With the midterm election weeks away, campaigns in countdown mode and inflation dominating the domestic agenda, the regulatory climate for healthcare in 2023 is predictable yet perplexing for a number of reasons.

Congress: Operating at an Impasse
Polls show Democrats face headwinds with voters going into the November election. Voter discontent about inflation is the primary concern, along with growing anxiety about an economic recession.

6,139 MEASURES PASSED
on healthcare issues by state legislatures from Jan. 1 to Aug. 25, 2021.
Source: Ballotpedia

Historically, the incumbent president's party loses seats in its first midterm: In the last 130 years, the average loss in the House of Representatives has been 28 seats. In 2010, Barack Obama lost 63 House and six Senate seats, and in 2018, Donald Trump lost 40 House seats and gained two Senate seats. The *Cook Political Report* predicts there will be 30 competitive races, but the general consensus is that

Republicans will take control of the House.

It is possible the Senate will shift to Democratic control, breaking the 50-50 deadlock, but that is of less consequence since major legislation requires 60 votes to pass in the upper chamber. Thus, with Congress in Republican control, the White House in Democratic control and the judicial branch, including the Supreme Court and the U.S. Court of Appeals, more cautionary, there are two primary implications for healthcare regulation next year:

New, major legislation impacting healthcare, including spending bills, is unlikely. That means any bills introduced concerning drug pricing, insurance subsidies, Medicaid, abortion and others will be stymied in committee and never make it to floor votes.

Federal agency rules and White House executive orders will drive industry changes from the executive branch. The focus will be on the Federal Trade Commission's constraints on hospital consolidation and the Department of Health and Human Services' enforcement of price transparency executive orders and Healthcare.gov insurance exchange directives. Additionally,

incentives to address equity, changes to alternative payment models, and modifications of Medicare Advantage risk-scoring and reimbursement will be top priorities for the Centers for Medicare & Medicaid Services. These efforts will be coordinated through the executive branch with an eye toward pending elections.

The specter of the 2024 campaign will flavor every proposed federal and state healthcare regulatory proposal.

Increase in State Healthcare Regulatory Actions
On Nov. 8, 39 governors in 34 states and five territories and 88 of the country's 99 state legislative chambers are up for election, with healthcare issues on the ballot in each state. From Jan. 1 to Aug. 25, 2021, state legislatures passed 6,139 measures on healthcare issues—second only to education (8,686), according to the website Ballotpedia. Inevitably, state-focused advocacy efforts about rules and regulations will become more important and more complicated in the following ways:

Partisanship will matter in state health policies and regulatory actions. As of June 8, Republicans controlled 54.3% of all state legislative seats nationally and Democrats held 44.4%. Republicans also held a majority in 62 chambers while Democrats held the majority in 36 (the Alaska House is organized under a multipartisan, power-sharing

coalition). In Republican-controlled legislatures, healthcare spending constraint has been the primary concern whereas in Democrat-controlled legislatures, affordability and access have been the primary areas of focus. Although there's bipartisan agreement about the importance of the health system, opinions about its strengths and shortcomings vary dramatically by party affiliation, and solutions are frequently filtered through a partisan lens.

States exercise primary control for many major healthcare issues. Consider that 38 states have expanded their Medicaid program since 2010, but voters in 12 of those states have pushed back. Additionally, states will determine how abortion rights are defined. States have wide latitude in licensing most health professionals, certifying health insurance plans sold in-state and marketplaces where individuals and small businesses access insurance subsidies, and much more.

However, there's wide variability in how states organize and regulate healthcare. For example, 35 states have certificate-of-need laws, 25 allow advanced practice nurses to practice without direct oversight by a physician and 30 have interstate compacts whereby physicians can practice across state lines.

States also manage public health programs, including preparedness for next-wave pandemics, and 27 states have hospital rate-setting or review authority, and at least 22 states authorize prescription drug price changes within defined parameters. Furthermore, state officials, such as an attorney general,

can file lawsuits on behalf of the state's citizens to halt hospital mergers or challenge predatory pricing.

As a result, state-level health policies are adapted to local and regional circumstances, the strength of the state's economy and voter preferences. At best, they can be projected to regional policymaking, but rarely more.

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Most regulations that pass federal and state legislative bodies will be popular with voters and involve considerably low political risk to incumbents.

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Increased activity in the courts. As reflected in the Supreme Court's action in Dobbs v. Jackson Women's Health Organization, which effectively negated Roe v. Wade and delegated abortion regulations to states, the court system will increasingly be a catalyst for healthcare-regulated activities and a prominent focus in healthcare politics. A number of court challenges addressing healthcare issues are anticipated, including abortion rights, minimum coverage in health insurance plans and hospital consolidation.

Implications for 2023
What do these changes to the U.S. healthcare regulatory agenda mean for hospitals, health systems and other healthcare organizations?

Most regulations that pass federal and state legislative bodies will

be popular with voters and involve considerably low political risk to incumbents. In healthcare, the following are safe bets: incremental regulations that reduce drug prices in targeted nonspecialty classes, increased price transparency requirements for hospitals and physicians, increased public surveillance and reporting about nursing home safety, and expanded availability of primary, preventive and mental health services through telehealth and broadband capabilities.

Consolidation among hospitals will slow. The FTC will be aggressive in challenging hospital consolidation deemed to harm competition. Thus, for hospitals, growth strategies will require diversification and/or strategic partnerships that provide scale while averting litigation.

The specter of the 2024 campaign will flavor every proposed federal and state healthcare regulatory proposal. At least 25 presidential campaigns will be launched in 2023, with each likely promising transformation of the health system through such areas as equal access, greater affordability, elimination of waste and price gouging. The rhetoric of these campaigns will prompt an elevation of healthcare in the public psyche and greater curiosity about "better solutions."

Finally, each healthcare organization can expect to see the effectiveness of its advocacy strategy tested in 2023. ▲

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Where's the Fire?

What to do when every issue seems urgent.

Rand O'Leary, FACHE

The pandemic has required hospital CEOs to put certain priorities on the back burner so they could effectively respond to their communities' needs and ensure staff members' safety. As healthcare organizations emerge from crisis mode, however, it is clear that a lack of focus on pre-pandemic priorities has had a steep cost to these organizations and created new challenges. Healthcare leaders now face the daunting task of leading their teams in a new environment and with an overwhelming number of concerns that need to be addressed.

With many urgent issues calling for their attention, leaders should aim to discern among—and clearly communicate to each member of their organizations—which few priorities should receive their focus.

With many urgent issues calling for their attention, leaders should aim to discern among—and clearly communicate to each member of their organizations—which few priorities should receive their focus. For healthcare organizations to continue to serve their communities effectively, they must prioritize supporting their communities and staff, patient safety and quality, financial growth, and operational excellence. Following is advice for how leaders can stay focused on what matters most so they can deepen their impact on their organizations and communities.

Community Support

It's important for hospitals and health systems to understand that though communities are no longer in pandemic crisis mode, they are still struggling. Communities are navigating challenges such as lack of available mental health services, changes within their homeless populations, an unstable food supply, increased crime and the subsequent strain on local police departments, and an economic downturn exacerbated by businesses that closed during the pandemic but could not reopen.

Often, hospitals are one of the largest employers in a community and are deeply connected to its economic health. Yet health systems are more than mere economic engines; they serve an irreplaceable role in public health. To identify and help meet the needs of their community, healthcare leaders need to prioritize effective communication and collaboration with community leaders. The decision to make the needs of the community the top priority, even when so many other needs are competing for attention, has the power to form leaders into true community advocates and solidifies their personal values in a way that will shape the trajectory of their careers.

Staff Support

It is crucial that those within the healthcare community support each other so they are in a better position to support their patients and communities. The pandemic has created new stresses and strains within the hospital work environment and has exacerbated issues, such as clinician burnout, that existed pre-2020. Today's employees also are facing immense pressures from outside their work environment.

Healthcare professionals' work is physically and mentally challenging. Leaders have a responsibility to ensure they provide their colleagues the necessary support to help them meet these challenges head-on while keeping their personal health and well-being intact. To address these challenges, organizations can offer training, places within the facility for employees to rest and restore during the workday, and support groups where staff members can talk openly about the issues they're facing. Other examples of solutions

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include employee assistance programs and extensive executive rounding programs so leaders can better understand the challenges employees face and help in ways that are meaningful and effective.

Patient Safety and Quality

A lack of available staffing is an issue plaguing hospitals globally. An increase in temporary and travel staff, while helpful in responding to the staffing crisis, has made it more challenging to maintain a safe environment and a focus on quality outcomes for patients and staff. It seems the trend in temporary staff will continue to grow in the coming months, but healthcare organizations cannot allow quality or safety to degrade.

It is leaders' responsibility to clearly and consistently communicate the organization's quality and safety goals to all employees, but it takes an entire staff to create a culture of patient safety. This requires that employees feel confident in speaking up about potential safety issues. Leaders can encourage constant communication on these topics through daily safety huddles in each department, leadership rounding and clearly defined safety stop processes (staff-generated procedures that provide for an organized team response when an issue is identified that could potentially harm a patient or staff member). Like pulling a handle to stop the line at a factory, leaders need to make sure nothing "moves" until the safety issue is rectified.

Financial Growth

The upheaval of the past two years has had major financial implications. As organizations adjust to the current environment, it is crucial to resume focus on regular investment in the organization's long-term financial health. This is essential to hospitals' and health systems' ability to continuously improve themselves and deliver high-quality services to meet the evolving needs of patients.

Not every financial initiative has to result in a new bed tower—there are scalable ways to approach this. Examples include a new telehealth platform to reach new service areas or an expansion of mental health services. There are many ways to deliver care to the community, but keep in mind

which opportunities have the greatest potential to meet community need while promoting financial growth.

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The pandemic has required hospital CEOs to put certain priorities on the back burner so they could effectively respond to their communities' needs and ensure staff members' safety.

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Operational Excellence
It can be easy for leaders to become distracted by the crisis of the day, especially after two years of addressing the ever-changing circumstances of a once-in-a-century pandemic. It's essential, however, that organizations remind themselves daily about their overarching operational goals.

In primary care practices, that goal might be ensuring patients are seen regularly. In the ED, operational excellence could mean minimizing wait times. In hospitals, the focus may be on discharging patients efficiently into the appropriate level of care. Use of accurate and relevant metrics can help illuminate for leaders whether the staff's everyday work is adding up to the delivery of quality care that the organization seeks to provide. That is why it's so important for all staff to access trended data (via a dashboard, for instance) and compare it against a standard benchmark or goal, which leaders can review with their teams in daily huddles.

Part of growing as a leader is learning to discern which key areas must be made a top priority when every issue seems

urgent. The current transition into an endemic state is an ideal training ground for healthcare leaders as they address challenges that have not received close attention in over two years. Now is the time for leaders and organizations to refocus on supporting their communities and staff, patient safety and quality, financial growth, and operational excellence to strengthen their organizations and communities. ▲

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Should Only CEOs Report to Their Boards?

Carefully consider the pros and cons of this proposition.

James E. Orlikoff

A core premise of governance is that the board has only one direct report: the CEO. The theory is, however, that the board also oversees other executives, and the entire organization, through its oversight of the CEO. Although this has been the standard recommended practice for over a century, it is not unlawful for a board to hire, evaluate or terminate executives other than the CEO.

Recently, due to the expanding responsibilities, accountabilities and liabilities of healthcare boards, and the growing complexity of governing hospitals and systems, there has been an emerging trend to have other executives report to the board. This can be either directly or with dual reporting relationships to both the CEO and the board. Further, healthcare compensation consulting firms are recommending to their clients that the board or board compensation committee should specifically approve the compensation of all senior executives, in addition to that of the CEO. Although this practice does not explicitly mean those non-CEO executives report to the board, it certainly creates a slippery slope in that direction.

As this budding trend risks the incremental erosion of recommended and time-tested governance practices, the question is posed: Is it a good idea to have executives other than the CEO report to the board?

The Five Components of a Direct Reporting Relationship
Typically, there are five related components of a direct reporting relationship:

Pros and Cons of Having Other Executives Report to the Board

PROS:
- May enable the board to have better oversight of functions for which it has increased responsibility and liability through direct communication with and oversight of executives responsible for those functions.
- May expand and improve the level of transparency the board has regarding the organization through reports and perspectives provided by executives with direct accountability to the board.
- May be a natural and necessary response to the growing number of executives in the C-suite to enable the CEO to maintain a manageable span of control.
- May be necessary to comply with future changes in regulatory requirements.
- May be necessary to recruit and retain talented board members to assuage their concerns about growing liability and reputational risk exposure.

CONS:
- Multiple reports pull the board into performing more executive—as opposed to governance—functions, which risks blurring the distinction between governance and management.
- Dilutes the authority of the CEO, which is risky and creates possibilities for other executives to bypass the CEO and go directly to the board.
- Creates a significant amount of additional work and time for the board, which adds to the growing governance burden.
- Creates ambiguity and potential for disagreement and conflict between the CEO and board in cases where the board and CEO have shared or divided authority over executives.
- Generates a sense that the board does not trust the CEO.
- Challenges the ability of the CEO to create and maintain an effective executive leadership team in that it lacks one clear leader, which is part of what makes an executive team successful.
- Undermines the strong and healthy board-CEO partnership necessary to organizational success.
- Risks increasing CEO and executive turnover rates.

hiring, firing, establishing performance objectives, performance evaluation and compensation. These five functions are usually exclusively performed by a single executive or by the board, but they can also be divided between or shared by the CEO and the board.

Board approval of the compensation of non-CEO executives is an example of this: The CEO may have the authority to hire, fire, set performance objectives and conduct performance evaluations for these executives, and may even recommend compensation adjustments, but it is the board or board compensation committee that has the ultimate authority to approve, modify or reject their compensation. In this example of a dual reporting relationship, both the CEO and the board are the "boss" of the executives because the authority for the five components has been divided between the board and the CEO. However, who is the "real" or most important boss? Is it the one who oversees more of the five components? Is one of the components, like firing authority, dispositive?

Dual Reporting Relationships
There is another type of dual reporting relationship, and that is where the CEO and the board share some or all of the five components. For example, the authority to hire an executive could rest with the CEO *and* the board, and both would have to agree to hire the executive. But, once hired, the CEO could have the authority over performance objectives and evaluations, compensation and firing for the executive. There are many possible permutations of the variables of there being two bosses and who has authority over the five components of being a boss.

In addition, there are several executive positions other than CEO that are typically regarded as candidates for direct or dual reporting relationships to the board. These include the COO, the chief legal officer, the chief governance officer, the head of internal audit and the director of compliance.

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There are several executive positions other than CEO that are typically regarded as candidates for direct or dual reporting relationships to the board.

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Other Executive Positions That Could Report to the Board
Consider the case where a chief legal officer has a direct and sole reporting relationship to the board. The board may desire this relationship to help ensure it is being best protected from liability. But is the CLO representing the board, the corporation or both? Typically, the chief legal officer's duties and loyalties focus on providing legal counsel consistent with the best interests of the corporation, as opposed to those of the board. Although these are often the same, they can diverge, usually in periods of severe crisis.

If they do, the chief legal officer, even if a direct report to the board, is still an employee of the organization and must first represent its best interests, not those of the board or its members. Thus, it is difficult to see what might be gained by having the chief legal officer report directly to the board. If the board needs legal advice

or representation on governance matters, consider an outside attorney to do that and only that.

However, that critique does not apply to the other executive positions that are often candidates for reporting to the board. Arguments can be made that a chief governance officer should report to the board as that position supports board function and operations. Similarly, the internal auditor and compliance officer could arguably report to the board to assure integrity of the functions and independence from the CEO, and so on.

Considerations
Before modifying the time-honored practice of the board having only the CEO as its one direct report, carefully consider the pros and cons (see sidebar on Page 44) of having executives other than the CEO report to the board, or of having dual reporting relationships. The decision to modify this practice should not be made implicitly, lightly or based solely on recommendations of compensation consultants.

Rather, base it on careful consideration of the rationale and potential consequences of such an expansion of the board's role as a boss. Changing the fundamental responsibility of the board, the authority of the CEO, and the dynamic of the board-CEO relationship are profoundly significant actions with many potential consequences and implications for the board, the CEO and the organization. ▲

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Avoiding "Drift" Into Harm

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Reinforce effective safety practices by addressing workarounds.

Patricia A. McGaffigan, RN

The melody of the nursery rhyme "Rock-a-Bye Baby" is recognized around the world. It elicits an image of a cradled baby perched high in a tree, lulled to sleep by gentle breezes. Suddenly, the bough breaks, and the cradle and baby fall. The workaround to let nature do the rocking has worked—until it has failed.

Every day, actions, inactions, choices and practices, while well-intended, load stress onto the boughs of our tree of safety. The boughs routinely bend, and sometimes break, as illustrated by the case of a former Tennessee nurse convicted after a medication error led to the death of a patient in 2017.

Though the case has sparked justifiable outcry and debate over the criminalization of medical errors, it also highlights vital lessons that healthcare leaders—the metaphorical arborists of safety—can take to identify, prevent and address choices, practices and conditions that lead to the bending and breaking of boughs.

Leaders understand safety is a dynamic property of a complex system and that it's their responsibility to strengthen safety through the systems, processes, cultures and behaviors necessary for safe and reliable care. Safety in healthcare depends on the collective vigilance of an entire organization to avoid being lulled into a false sense of security, believing that because no "boughs" have broken recently, everyone is safe. The reality is that every day in healthcare, clinicians make choices and operate in conditions that are not safe.

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Given the ubiquitous risk of errors across all healthcare settings, leaders need to take action regardless of their organization's record on, or reputation for, safety.

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Sidney Dekker, PhD, professor at Griffith University in Brisbane, Australia, and an expert in human factors and safety systems, asserts that the unintentional (and often unnoticed) "drift" from effective safety practices is the root cause of human error. This drift incubates slowly and is often not recognized until a serious event occurs. Actual practice is decoupled from the standards, practices and professional accountability that were acknowledged as necessary for safety, and this new performance is gradually routinized and tolerated by the system, as long as no immediate adverse events or outcomes occur. Dekker calls this "normalization of deviance."

Normalization of Deviance
Common causes of normalization of deviance in healthcare include rules that don't make sense and impede productivity, particularly when under time pressure and heavy patient loads. Normalized deviance commonly results when imagined or desired work fails to align with the realities of actual work and when technologies intended to support safety disrupt performance instead.

Workarounds—behaviors that deviate from prescribed practices—are shortcuts to accomplish a goal more readily in the face of perceived or real barriers. Normalization of workarounds happens when repeated patterns of deviation do not result in harm, leading to the belief that harm from these deviations is not possible. Normalization also occurs when individuals believe that rules don't apply to them because they are good at their jobs and not inclined to make mistakes, or when they believe that a different approach is justified for the patient.

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Normalization calcifies when staff are afraid to speak up when they observe deviations, fearing punitive action for doing so, or they are discouraged by prior reports that have not resulted in change.

Finally, normalization of deviance is perpetuated when leaders fail to recognize and accurately convey the implications of such practice, dilute and downplay the findings of system faults or choose to overlook challenges that may be resource-intensive and costly to address.

Examples of normalized deviation persist across healthcare, and common examples include failure to check patient identifiers prior to administering medications, batch preparation of medications for multiple patients at a time, failure to re-sheath needles prior to disposal, failure to follow personal protective and infection control practices, such as handwashing, and failure to use checklists.

System Design Defects
Latent errors result from underlying, and therefore less visible, defects in the design of systems, environments and technologies. These defects erode the protective defenses of systems and allow errors to reach the patient. Latent errors set the stage for vulnerability and harm and often emerge due to lack of, poorly designed or malfunctioning systems; weak supervision; inadequate policies; unclear roles and responsibilities; and communication breakdowns. The compounding of latent and active failures heightens the risk of adverse events.

The Tennessee nurse case offers insight into a multitude of active and latent failures that may have contributed to the medication error that caused the patient's death. They offer important signs deserving of our attention such as overrides of the automated medication dispensing cabinet being reported as common practice to avoid delays (strongly suggesting normalization of this workaround); EHR upgrades that can contribute to delays in accessing medications from the ADC; dangerous paralytic agents (like the medication that led to the patient's death) not being excluded from the ADC override list, nor sequestered from other medications; a failure to confirm the name of the medication on the front label of the vial dispensed from the ADC; the absence of barcode scanning technology and access to an EHR in the radiology setting where the medication was ultimately administered; and the lack of clear policies and procedures for monitoring patients who receive anxiolytics (the medication the patient should have received).

Course of Action
Given the ubiquitous risk of errors across all healthcare settings, leaders need to take action regardless of their organization's record on, or reputation for, safety. Here are suggested actions:

- Fully commit to safe and reliable care and the elimination of harm as the daily work of leaders and the organization. The *National Action Plan to Advance Patient Safety* and *Leading a Culture of Safety: A Blueprint for Leaders* are two resources from the IHI Lucian Leape Institute and ACHE that provide guidance for leaders.

- Embrace high-reliability principles in the intentional design of systems, and ensure professional accountability for safe and reliable care for everyone in the organization.

- Acknowledge the propensity of humans to "drift." Anticipate, seek out and understand the frequency and causes of deviation, such as overrides and workarounds, and act when such practices are identified before harm occurs. Conduct interprofessional, proactive risk assessments to understand the frequency, rationale and locations of overrides, near misses and harm events. Share trends, examples of positive deviation that accomplish goals while not compromising safety, and priorities for improvement.

- Incorporate questions about drift and workarounds into safety huddles, and engage staff in identifying areas for improvement.

- Implement technologies designed to promote safety (e.g., barcode medication administration solutions, five-letter drug entry for medication search and selection, EHR alerts and alarms) and standardize solutions across settings whenever possible.

- Anticipate what might go wrong with technologies before implementation, and in advance of upgrades and user interface changes.

- Engage safety experts, human factors experts, direct care team

members, patient and family advocates, and technology vendors in human-centered design, implementation, monitoring and evaluation of solutions to eliminate risks. Use action hierarchy, a component of Root Cause Analysis and Action, or RCA² "squared," to identify strong and intermediate actions beyond weaker actions, such as training and protocol revisions, to mitigate or prevent adverse events.

- Embrace the five rights of medication use and fair and just culture models to evaluate and design policies, procedures, systems and expected behaviors *before* any harm occurs.

- Encourage and reward reporting of near misses and harm events.

- Ensure full support and transparency for patients, families and the workforce when errors and harm occur.

This is a long list, to be sure. But together, intentional steps are necessary to significantly improve and sustain safety by identifying and preventing the normalization of deviance before harm occurs. ▲

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Editor's note: *The National Action Plan*, blueprint, Action Hierarchy tool and other safety resources are available at ihi.org and **ache.org/ Safety**.
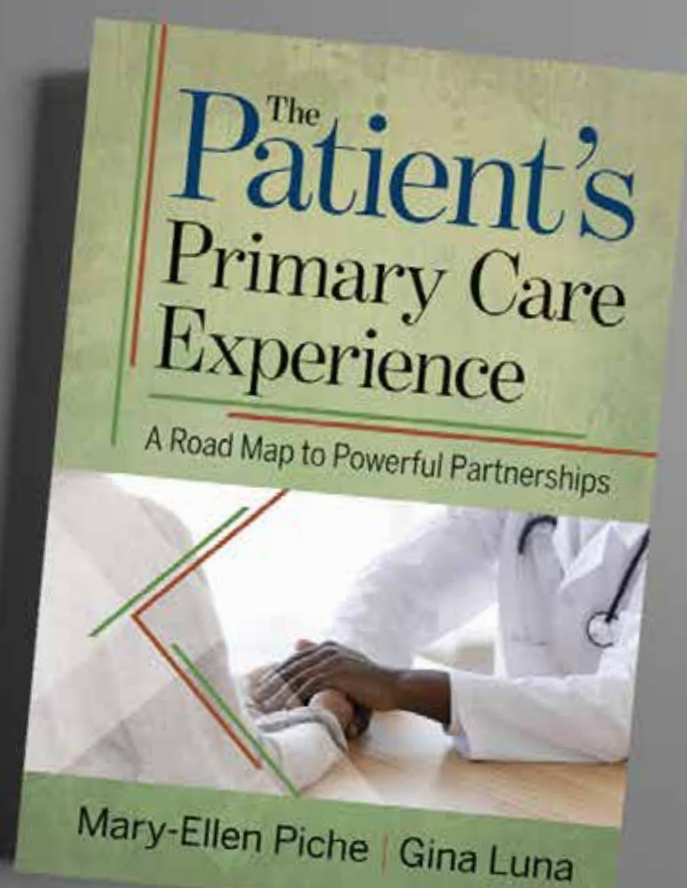
Diane L. Dixon, EdD

Brett D. Lee, PhD, FACHE

Harnessing Diverse Leadership Talent

Sponsorship can play a significant role.

Sponsorship is a way to foster diverse leadership talent and prepare individuals for advancement to the executive level. Although many healthcare organizations have a stated goal of enhancing diversity at the executive level, executing this goal effectively often remains a challenge and an opportunity. The percentages of diverse executive leaders, especially people from various racial and ethnic backgrounds, women, and other underrepresented groups, remain low in comparison with the populations that health systems serve.

70% OF LEARNING

comes from experience-driven leadership development, 20% from developmental relationships, and 10% from formal training and education.
Source: Center for Creative Leadership

Making a commitment to strategically develop diverse talent can produce tangible benefits for organizational performance. Diverse leadership teams can advance that commitment by enhancing relationships in the communities they serve, attracting diverse talent at all levels and making health equity a strategic priority. Organizations with greater leadership diversity have higher performance on key operational metrics, improved decision-making and increased innovation, according to research conducted by McKinsey & Company, the results of which were published in a report, *Diversity wins: How inclusion matters*, in May 2020. When CEOs and other senior executives embrace sponsorship as a key component of a comprehensive approach to leadership development, they can play a significant role in harnessing diverse leadership talent.

Sponsorship Defined
Sponsorship is a professional relationship in which senior leaders engage in dedicated actions to advocate for and advance the careers of high-potential talent. It is a two-way relationship between the sponsor and a talented up-and-comer that involves other influential leaders who can provide that individual with leadership opportunities and experience. There is reciprocity between the sponsor and protégé with a return on the investment. The sponsor advances his or her own leadership by developing diverse talent bench strength, and the emerging leader delivers high performance that benefits the organization.

Sponsorship Differs From Mentorship
Sponsorship is related to, but different from, mentorship. Mentorship is a professional relationship in which a more experienced individual provides advice, guidance, support and encouragement to enhance the career growth of the mentee. The relationship is between the mentor and mentee and usually does not involve others. A mentor may become a sponsor. As the mentor learns about the mentee's leadership capabilities and potential, they may decide to advocate for their advancement.

Both sponsorship and mentorship are essential for leadership development and advancement, but sponsors take their responsibilities for advancing the careers of others a step further than mentors.

This column is made possible in part by Quest Diagnostics.

What Sponsors Do

Sponsors move beyond just providing guidance as a mentor to actively making an investment in the experience-driven leadership development of the individual they are sponsoring. This experience-based approach is in line with how leaders tend to learn most effectively. Research on how executives learn and grow indicates that the optimal mix is when 70% of learning comes from experience-driven leadership development, 20% comes from developmental relationships and 10% comes from formal training and education, according to a Nov. 24, 2020, article, "The 70-20-10 Rule for Leadership Development," by the Center for Creative Leadership.

The CEO's early efforts may be to educate the leadership team on the role of sponsors and the benefit that a formal sponsorship program can provide to the organization.

Furthermore, research published in the book *Diversity on the Executive Path: Wisdom and Insights for Navigating to the Highest Levels of Healthcare Leadership* about the career trajectory experiences of racially and ethnically diverse CEOs found that sponsors recommend sponsored individuals for challenging experiences and assignments that facilitate advancement. In addition, sponsors use their social and political capital to advocate for the up-and-coming leader. They tell other executives about the sponsored individual's leadership capabilities and performance, and they expand their network by connecting them to other senior executives who can potentially influence their advancement.

Sponsors help protégés navigate the political dynamics of the organization and protect them from potentially toxic situations. A good sponsor guides, supports and nurtures the rising leader.

CEO Sponsorship Role

The CEO, working with the executive leadership team, can thoughtfully create an inclusive and

equitable organizational culture that makes leadership diversity a strategic priority. Sponsorship programs are still relatively rare in healthcare organizations. As such, the CEO's early efforts may be to educate the leadership team on the role of sponsors and the benefit that a formal sponsorship program can provide to the organization. Sponsorship should be embedded in the broader leadership development strategies so that it has the infrastructure and support systems to be sustainable.

The CEO can also provide guidance on important structural questions regarding a sponsorship program. For example, will sponsors be formally assigned to their protégé or will relationships develop organically, and how will these talented individuals be identified and selected? This leadership development practice helps to ensure that there is a talent pipeline with high-potential diverse leaders ready for succession to key leadership positions.

CEOs develop an inclusive and equitable culture that makes sponsorship essential by what they pay attention to, what they routinely talk about, what they measure, what they reward, what they make visible and by being sponsors themselves. By doing so, CEOs set the stage for sponsorship to become an important practice that leaders have accountability for implementing throughout the organization.

Sponsorship Readiness
Engaging in sponsorship is a tremendous responsibility that requires a commitment of time, strategic thinking and personal

leadership relationship equity to actively advance the career of others. It requires an even bigger effort to incorporate sponsorship into the organization's leadership development strategy and succession planning. This makes assessing readiness for sponsorship important. Here are three questions to initiate that assessment as a CEO:

- Do I believe that harnessing diverse leadership talent is integral to executing the organizational strategy?

- Am I willing to share my time, expertise and political acumen to advance the careers of diverse leaders?

- Do I spend time with the senior leadership team discussing inclusive leadership development strategies and succession planning?

If the responses indicate readiness to improve sponsorship, the CEO and senior leadership team can further assess the current state of sponsorship. With this understanding, the executive team can start developing an improvement action plan.

The Sponsorship Advantage
The CEO is ultimately responsible for creating an inclusive organizational culture in which all people have a fair opportunity to develop their leadership capabilities and experience unbiased career advancement. Because historically underrepresented groups may be less visible in traditional leadership development talent pools, executives can make a more deliberate commitment to seek out diverse

talent and assist this population in navigating the complexities of healthcare organizations.

....

Sponsorship is a professional relationship in which senior leaders engage in dedicated actions to advocate for and advance the careers of high-potential talent.

....

While there may be some initial resistance to investing time and energy, as well as reputation and political capital, to help develop a talented rising leader, the results pay dividends. Sponsors experience great pride and ownership when the protégés with whom they work achieve success, and this can be a powerful retention tool for both the sponsor and the protégé alike. In this time of the "Great Resignation," this is a competitive advantage.

Sponsorship can play a significant role in developing diverse talent that benefits the entire organization. With inclusive leadership, executives create a powerful tapestry of different backgrounds, experiences, lenses and perspectives that can advance the current strategy and foster innovation going forward. ▲

Diane L. Dixon, EdD, is managing principal, D. Dixon & Associates and an ACHE Member (Diane@ddixon.org). Brett D. Lee, PhD, FACHE, is president, Texas Health Hospital Frisco (brettlee@texashealth.org).

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Rina Bansal, MD

John S. Budd, FACHE

Building a Care Team at the Top

Why clinician C-suite representation matters and how to achieve it.

The core business of health systems is making people better. Across America, doctors, nurses, radiology techs and a litany of well-qualified executives with an alphabet soup of credentials are doing just that. They palpate, auscultate, prescribe and administer. They listen, hold hands, grieve and celebrate. These clinicians are practically everywhere in health systems except for one place.

Senior Leadership and Governance
An analysis of hospital executive information across more than 6,100 hospitals—conducted by ECG Management Consultants using data from IRS 990s and the Medicare Cost Report to collect executive and board information for a large portion of hospitals across the United States—shows the degree in which physicians and nurses are represented at the most senior levels of organizational management and governance. Physicians and nurses account for 17.7% of board seats and 16.9% of CEOs.

With turnover and clinician burnout at an all-time high, the importance of representative leadership is the key to future-proofing health systems. Clinicians in leadership can lead to higher levels of staff engagement, lower turnover and better clinical outcomes, and employees want to work for organizations where they share common

experiences with their leaders and coworkers. Workplace belonging leads to a 56% higher job performance and employees are 50% less likely to leave, according to research conducted by talent and retention firm BetterUp, which appeared in a 2019 *Harvard Business Review* article.

To retain high-performing staff and grow, health systems need to prepare and elevate clinicians to lead.

Though physicians, practitioners and clinical care providers make up more than 61% of the total hospital workforce, according 2020 data from the U.S. Bureau of Labor Statistics, their lack of representation in leadership may make it hard for them to see themselves as a part of the broader organization and its strategy. One can argue that clinical leadership positions, such as clinical director or medical director, or even CMO and CNO roles, are abundant. However, many clinicians are woefully underprepared to take on these roles.

Time and again, we have seen clinical leaders get promoted based on their clinical acumen and not leadership skills. Those who succeed either have inherent leadership skills or make an intentional effort to develop

themselves. To retain high-performing staff and grow, health systems need to prepare and elevate clinicians to lead. Delivering on this strategy will require boards and senior executives to focus on several key activities.

Formalizing Leadership Development
By the time a senior executive role or a board seat opens, it can already be too late for an internal candidate. Clinicians who have spent their career with the organization may lack the formal leadership experience and training that an external applicant may have. The best solution is to create formal leadership development programs that train clinicians well in advance of a vacancy.

Program training may include Lean Six Sigma, finance and accounting, and be structured to fit into a busy practitioner or shift-based schedule; however, effective leadership development goes beyond simply coursework to also include opportunities to apply

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what students are learning regularly. For example, a real-world leadership development program may consist of clinicians paired with a mentor to identify, design and execute a process improvement initiative. This will allow an organization to assess current leadership skills and aptitudes of its aspiring clinicians and identify learning opportunities for current and future clinical leaders. Creating opportunities for clinicians to lead process improvement initiatives can also lead to new innovations for the organization.

....

Health systems find success when they formalize and communicate the steps on the ladder to those higher leadership roles, support team members in getting to the next rung, and offer ample opportunities to explore new career paths outside of pure care delivery.

....

Defining a Career Ladder With Options
Employees want to work in organizations that are invested in their career growth. A 2021 Pew Research study found that limited opportunity for advancement was the No. 2 reason given for employees choosing to leave their job. For many, the path from practicing clinical team member to the C-suite can be difficult to imagine. Health systems find success when they formalize and communicate the steps on the ladder to those higher leadership roles, support team members in getting to the next rung, and offer ample opportunities to explore new career paths outside of pure care delivery.

Traditional clinical career ladders end as a CNO or CMO, but to prepare clinicians to be leaders outside of these roles, it is essential to offer opportunities to branch out. This may involve creating new leadership roles that incorporate nontraditional areas into the spans of control of what traditionally have been clinically oriented positions.

Including Clinicians in Big Decisions and Governance
For many organizations, clinicians are included in decisions in which the primary impact is clinical, but the decisions of a CEO and the board often span multiple domains. In fact, many executive teams function in this manner. A 2014 study by the American Hospital Association found that CMOs were "always involved" in regular executive team decision-making about 53% of the time, while CNOs were involved 47% of the time.

Similarly, at the board level, clinicians are often brought in to represent the medical staff or quality measures. As health systems explore how they can expand the role of clinical leaders, it will be critical to bring clinical leaders into a broader range of organizational decisions. This can mean identifying a physician leader to serve on the position control committee or adding a someone from pharmacy onto the board finance committee. ▲

Rina Bansal, MD, is president of Inova Health System, Alexandria, Va. (rina.bansal@inova.org) and an ACHE Member. John S. Budd, FACHE, is president of the National Capital Healthcare Executives and an associate principal with ECG Management Consultants, Arlington, Va. (jbudd@ecgmc.com).

ACHE Recognizes 2022 Joint Federal Sector Award Recipients

This year, ACHE had the privilege of recognizing three individuals with the following awards, established to recognize healthcare management excellence in the federal sector:

Mark J. Stevenson, FACHE, chief operations, Program Management Office, Defense Health Agency, Aurora, Colo.,

Stevenson

received the 2022 Federal Excellence in Healthcare Leadership Award, which recognizes a federal civilian or uniformed ACHE Fellow who has made significant contributions to ACHE and the profession of healthcare administration. The Federal Excellence in Healthcare Leadership Award is sponsored by retired Brig Gen Donald B. Wagner, LFACHE,

The 2022 Federal Excellence in Healthcare Leadership Award presented to Mark J. Stevenson, FACHE.

former Deputy Surgeon General for Operations and chief of the Air Force Medical Service Corps.

Sarah K. Poulos, FACHE, Veterans Integrated Service Network 5 chief business officer, VA Capitol Health Care Network, Linthicum, Md., received the 2022

Poulos

Federal Excellence in Healthcare Management Award, which recognizes one nonuniformed federal civilian ACHE member at the grade of GS-14 or below who developed and led innovative practices in healthcare management.

LCDR Temitope O. Ayeni, FACHE, executive assistant, Office of the Chief of Naval Operations, Washington, D.C., received the 2022

Ayeni

Military Excellence in Healthcare Management Award, which recognizes one uniformed ACHE member who developed and led innovative practices in healthcare management.

These three individuals received their awards March 31 during the Joint Federal Sector Breakfast and Awards Ceremony, held immediately after the 2022 Congress on Healthcare Leadership in Chicago, March 28–30.

2022 Scholars Selected for Executive Diversity and Career Accelerator Programs

Thirty-seven scholars have been selected for the 2022 Thomas C. Dolan Executive Diversity (12) and Career Accelerator Programs (25). Nearly 180 high-caliber executives applied for these prestigious national programs, which provide education, mentoring and networking experiences to prepare diverse leaders for higher-level positions in hospitals, health systems and other healthcare organizations.

The Executive Diversity Program has offered specialized leadership development for diverse leaders since it was established in 2014 by the Foundation of ACHE's Fund for Healthcare Leadership to honor Thomas C. Dolan, PhD, FACHE,

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who served as president/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 offerings were expanded to include the Career Accelerator Program, designed for diverse midcareerists to support their career advancement.

The scholars and their respective organizations are:

Executive Diversity Program
Stacey Ann-Okoth, DNP, RN, NEA-BC, CNO, Jefferson Health-Abington (Pa.) Division.

Juana Hutchinson-Colas, MD, associate professor/chief, Division of Female Pelvic Medicine and Reconstructive Surgery, Rutgers Robert Wood Johnson Medical School, New Brunswick, N.J.

Megha Kachalia, FACHE, assistant vice president, Physician and Ambulatory Planning, MedStar Health, Washington, D.C./ Baltimore.

Pranav C. Mehta, MD, FACHE, CMO/vice president, Clinical Operations, HCA Healthcare Group, Nashville, Tenn.

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

Sonney Sapra, CIO, Samaritan Health Services, Corvallis, Ore.

Sanjit Sodhi, CFO/interim COO, Kaiser Permanente-Napa/Solano, Oakland, Calif.

Marilyn A. Swindle, DNP, RN, CPHQ, associate vice president, Clinical Effectiveness, Memorial Hermann Health System, Houston.

Amanda S. Tufano, FACHE, CEO, Genevive, Minneapolis.

Alen Voskanian, MD, medical director, Cedars-Sinai Medical Group, Los Angeles.

Dorian L. Williams, FACHE, assistant vice president, Operations, West Virginia University Medicine, Morgantown, W.Va.

Robin Womeodu, MD, senior vice president/chief academic officer, Methodist Healthcare, Memphis, Tenn.

Career Accelerator Program
Veronica Angel, director, Evolve Psychiatry Treatment Centers, El Segundo, Calif.

Ardith C. Barrow, FACHE, director, Strategic Consulting, Wellstar Health System, Alpharetta, Ga.

Gabrielle L. Besler, clinical operations director, Department of Otolaryngology/Head and Neck Surgery, UC Health, Cincinnati.

Frantz M. Berthaud, marketing director, Oncology Services, The Hospitals of Providence, El Paso, Texas.

Timothy L. Brown, DHA, director, People and Culture, WorkReduce

Inc., Charlotte, N.C.

Pedro "Paco" C. Castellon, director, Research, Sylvester Comprehensive Cancer Center, Miami.

Ahn Thang Dao-Shah, PhD, executive director, Belonging and Equity, John Muir Health, Walnut Creek, Calif.

Bri Dinoso, director, Clinical Innovation, Kaiser Permanente, Castro Valley, Calif.

Nwando U. Eze, MD, regional medical director, Neonatology, The Permanente Medical Group Northern California, Granite Bay, Calif.

Frankie N. Hamilton, CPHQ, NEA-BC, deputy CNO, New York City Health and Hospital Corporation of Lincoln Hospital, New York.

Jason Hart, FACHE, senior director, Multispecialty Clinics, Alaska Native Tribal Health Consortium, Anchorage, Alaska.

In Memoriam

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

Robert E. Lawson, FACHE
Newark, Del.

Andrew Patterson, FACHE
Sanbornton, N.H.

Steven Hunter, DMSc, director, Advanced Practice Professionals, Baylor Scott & White, The Heart Hospitals, Plano, Texas.

Lawrence D. King, nursing home administrator, Twin Oaks Rehabilitation & HealthCare Center, Mobile, Ala.

Mark Liu, director, Strategic Initiatives for Oncology, Mount Sinai Health System, New York.

Jemichael Manora, chief of safety/emergency management service, Central Alabama Veterans Health Care System, Montgomery, Ala.

Salman Moti, DHA, director, Health System Quality Operations-Analytics, UT Southwestern Medical Center, Dallas.

Paul S. Persaud, executive director, Patient Experience, Landmark Health, Lindenhurst, N.Y.

Lakshmi Seshadri, MD, medical director, Utilization Management, Aetna CVS Health, Sugar Land, Texas.

Alexandra Simonton, director, Strategy, IU Health, Carmel, Ind.

Lena Simpson, assistant chief, HIMS, West Palm Beach VA Medical Center, Hialeah, Fla.

Raman Singh, RN, FACHE, CPHQ, director, Operations, Adventist Health, Handford, Calif.

Cassandra Stephenson, administrator, Medical Services, Princeton (N.J.) University.

Jocelyn Thomas, regional manager, Infection Prevention, Memorial Hermann Health System, Houston.

Cyrilyn A. Walters, MD, medical director, Ambulatory Services, Regional One Health/UT Health Science Center, Memphis, Tenn.

Marisa Williams, senior manager, Atrium Health, Charlotte, N.C.

In 2022, the Executive Diversity Program will consist of e-learning, including live and recorded webinars, self-study materials and three multiday, in-person sessions. The Career Accelerator Program is exclusively virtual. 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.

Both the Executive Diversity Program and the Career Accelerator Program are wholly funded by the Fund for Healthcare Leadership. Visit **ache.org/DiversityPrograms** to learn more about the 2022 scholars and the Executive Diversity and Career Accelerator Programs.

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

Anthony A. Armada, FACHE Chair
ACHE Annual State Membership Meeting and Breakfast
Michigan Health & Hospital

Association Annual Membership Meeting
(June 2022)

Career Positioning—Proactively Managing Your Professional Development
ACHE—North Florida Chapter
(July 2022)

Delvecchio S. Finley, FACHE Chair-Elect
ACHE Breakfast
Ohio Hospital Association Annual Meeting & Education Summit
(June 2022)

ACHE Announces New Hires, Promotions and a Retirement

Following are new hire, promotion and retirement announcements.

Shannon N. Barnet promoted to manager, Product Marketing, Department of Marketing, from content marketing specialist.

La'Toya Carter welcomed as content acquisitions manager, Department of Learning/Health Administration Press.

Cristina Cuevas promoted to senior customer service representative, Customer Service Center, Department of Executive Engagement, from customer service representative.

Marina Garcia promoted to accounting specialist, Finance & Accounting, Department of Business Excellence, from accounting coordinator.

Kevin D. McLenithan welcomed as project editor, Department of Learning/Health Administration Press.

Nolan

Julie A. Nolan retired from director, Executive Office and Governance, in July after 38 years of service. Julie joined ACHE in 1984 as an accounting/order-entry clerk. She went on to be promoted to administrative secretary (1985), administrative assistant (1986), administrative assistant II (1988), special assistant to the president (1991), executive assistant to the president (1993), governance manager (2012) and, in 2014, her final role as director, Executive Office and Governance. During her tenure with ACHE, Julie served many staff, three ACHE presidents (Stuart A. Wesbury Jr., PhD, LFACHE; Thomas C. Dolan, PhD, FACHE; and Deborah J. Bowen, FACHE, CAE), 46 ACHE Chairs and countless volunteers. She has navigated an infinite number of committee assignments, requests, advancements in process and policy at the Board of Governors level, and recruited staff. Most importantly, Julie came to be known as the heart of ACHE. We would like to thank Julie for her many years of service to the organization and the healthcare field.

Lisa M. Redmond welcomed as customer service representative, Customer Service Center, Department of Executive Engagement.

Sujatha Socrates welcomed as web content coordinator, Department of Marketing.

Sylvia Vargas welcomed as meeting planner, Department of Professional Development.

Deneen Y. Wakefield promoted to senior customer service representative, Customer Service Center, Department of Executive Engagement, from customer service representative.

Nana Yaa A. Yiadom welcomed as customer service representative, Customer Service Center, Department of Executive Engagement.

Intern Announced

Morgan E. Krizan has been selected as the ACHE Diversity Intern through the Institute for Diversity and Health Equity's Summer Enrichment Program. Krizan is pursuing an MBA from Concordia University, St. Paul, N.D. She expects to graduate in August 2023.

The three-month internship offers exposure to a broad range of association management issues. The intern interacts with senior-level executives and rotates through each of ACHE's departments. The internship was established in 1991 to further postgraduate education in healthcare and professional society management.

Burnout Among Healthcare Leaders

Results by ACHE's Executive Office, Research.

Creating a resilient workforce has become a focus for many healthcare organizations. The pandemic underlined the presence and damaging effects of healthcare worker burnout at all levels. A simple definition of burnout is provided by Thom A. Mayer, MD, FACHE, founder, BestPractices, medical director, NFL Players Association and executive vice president, Leadership, LogixHealth, Bedford, Mass.: Burnout occurs when job stressors exceed the individual's adaptive capacity or resiliency to deal with those stressors.

Burnout is characterized by three symptoms: high emotional exhaustion, high depersonalization or cynicism, and a low sense of efficacy or personal accomplishment. There is general agreement in the literature that the causes of burnout include:

- Mismatch of job stressors and adaptive capacity or unsustainable workload.
- Perceived lack of control or autonomy.
- Insufficient rewards for effort.
- Lack of a supportive community.
- Lack of fairness.
- Mismatched values and skills.

There have been numerous studies of burnout among physicians, nurses and other front-line healthcare workers. In June 2021, ACHE collaborated with Mayer and Stanford University researchers Tait Shanafelt, MD, and Mickey Trockel, MD, PhD, to examine burnout and other stress-related symptoms among healthcare leaders. A survey was sent to 5,670 ACHE members holding positions of department head/director and above in healthcare provider organizations. Of those, 1,269 responded, resulting in a 22% response rate among eligible respondents who received the survey.

The survey results indicated that one-third of healthcare leaders in the study had burnout scores in the high range. Because leaders set the directions, standards and tone for their teams, and are responsible for maintaining their morale, this figure is of concern. The proportion of those with burnout scores in the high range by position are shown in the table below.

The percentage of leaders with burnout scores in the high range increases markedly for positions of vice president and below, although when controlling for other factors, managers stood out as more at risk of burnout than those in any positions above them. The survey did not collect reasons why this might be so, although several hypotheses can be proposed. Those in less senior positions have less autonomy, lower rewards and may be in more direct contact with front-line workers experiencing burnout than those in more senior positions. It may also be that those who achieve the most senior positions in their organizations are more likely to have developed effective strategies for dealing with job stress.

ACHE wishes to thank the healthcare leaders who responded to this survey for their time, consideration, and service to their profession and to healthcare leadership research.

Percent With Burnout Scores in the High Range by Position

Position Level	Percent With Burnout Scores in the High Range
CEO	70%
Other members of the C-suite or senior vice presidents	53%
Vice presidents	51%
Director/Department head	49%
Manager	46%

Cornue

Dahlen

Gill

Khan

King

Rodriguez Shirey

Scott Alwin to CEO, Hot Springs Health, Thermopolis, Wyo., from chief clinical officer.

Vi-Anne Antrum, DNP, RN, FACHE, to systemwide CNO, Cone Health, Greensboro, N.C., from interim systemwide CNO and associate chief nurse executive.

Jeanna Bamburg, FACHE, to CEO, The Woman's Hospital of Texas, Houston, from CEO, HCA Houston Healthcare Southeast.

Christopher M. "Chris" Cornue, FACHE, to chief strategy officer, Cone Health, Greensboro, N.C., from executive vice president, The Health Management Academy, Arlington, Va.

Gretchen M. Dahlen, LFACHE, president, Consumer Health Ratings, a public service of The Dahlen Company LLC, Verona, Wis., to retirement. We would like to thank Gretchen for her years of service to the healthcare field.

Alexander S. Gill, FACHE, to senior director, Strategic Services,

Children's Mercy, Kansas City, Mo., from department administrator.

Sarah T. Khan to chief clinical transformation officer, Jaan Health, Cincinnati, from principle, KIG Consulting, Walnut Creek, Calif.

Christopher J. King, PhD, FACHE, to dean, Georgetown University School of Health, Washington, D.C., from associate professor/chair, Department of Health Systems Administration, Georgetown University School of Nursing & Health Studies.

C. Brett Matens, FACHE, to CEO, Heart Hospital of Austin (Texas), from COO, HCA Healthcare Presbyterian/St. Luke's Medical Center, Denver.

Elif McCain to chief administrative officer, specialty healthcare, Fraser, Richfield, Minn., from senior director, Fraser Clinical Services.

Patrick Menzies, FACHE, to CEO, The Portland (Ore.) Clinic, from CEO, Boulder (Colo.) Medical Center.

Shawn D. Parekh, PharmD, FACHE, to vice president/chief pharmacy officer, Temple University Health System, Philadelphia, from vice president, Pharmacy/Chief Ancillary Officer Lab, Prospect Medical Holdings, Los Angeles.

R. Bradley Reeder, FACHE, to practice operations director, Aflac Cancer and Blood Disorders Center, Atlanta, from director, Physician Practice Operations, Children's Healthcare of Atlanta.

Joseph M. Scotchlas, FACHE, to deputy network director, VA Capitol Healthcare Network, Linthicum, Md., from assistant director, Bay Pines (Fla.) VA Healthcare System.

Maria Rodriguez Shirey, PhD, RN, FACHE, to dean, UAB School of Nursing, from associate dean, Clinical and Global Partnerships, and inaugural holder of UAB's Jane H. Brock–Florence Nightingale Endowed Professorship in Nursing.

This column is made possible in part by Exact Sciences.

EXACT SCIENCES

Want to submit?

Send your "On the Move" submission to he-editor@ache.org. Due to production lead times, entries must be received by Oct. 1 to be considered for the Jan/Feb issue.

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

James L. Andrews II, chief, Medical Administration Service, Gulf Coast Veterans Health Care System, Biloxi, Miss., received the Early Career Healthcare Executive Award from the Regent for Veterans Affairs.

Alessandra Cornelio, FACHE, program director, Disease Centers of Excellence, Hartford (Conn.) HealthCare, received the Early Career Healthcare Executive Award from the Regent for Connecticut.

Garcia Curtis received the Student Award from the Regent for Connecticut.

Denise J. Fiore, LFACHE, received the Senior-Level Healthcare Executive Award from the Regent for Connecticut.

Parker D. Harris, CEO, Baptist Memorial Hospital–Tipton (Tenn.), received the Exceptional Service Award from the Regent for Tennessee.

Brady W. Hoffman, director, health connections, Stormont Vail Health, Topeka, Kan., received the Early Career Healthcare Executive Award from the Regent for Kansas.

Monzer Hourani, CEO/president, Medistar Corporation and Integrated Viral Protection, Houston, received the Senior-Level Healthcare Executive Award from the Regent for Texas–Southeast.

Martha S. Mather, CEO, UofL Health–Peace Hospital, Louisville, Ky., received a 2022 Enterprising Women Award from *Louisville Business First*.

Samuel S. McCord, FACHE, director, physician practice, West Feliciana Hospital, St. Francisville, La., received the Early Career Healthcare Executive Award from the Regent for Louisiana.

Andrew D. McDonald Sr., FACHE, shareholder/practice leader, Physician Business Solutions, LBMC, Brentwood, Tenn., received the Rural Healthcare Executive Award from the Regent for Tennessee.

Clay W. Runnels, MD, FACHE, executive vice president/chief physician executive, Ballad Health, Kingsport, Tenn., received the Physician Leader Award from the Regent for Tennessee.

Alexandra Simonton, director, strategy, Indiana University Health, Indianapolis, received the Early Career Healthcare Executive Award from the Regent for Indiana.

Timothy A. Slocum, FACHE, president, Methodist University Hospital, Memphis, Tenn., received the Senior-Level Healthcare Executive Award from the Regent for Tennessee.

Howard A. Smith, DMSc, PA-C, chief, pediatric, Southwest Community Health Center, Bridgeport, Conn., received the Diversity, Equity & Inclusion Award from the Regent for Connecticut.

Terrie P. Sterling, FACHE, CEO, Terrie Sterling LLC, received the Senior-Level Healthcare Executive Award from the Regent for Louisiana.

Joseph Webb, DSc, FACHE, CEO, Nashville (Tenn.) General Hospital, received the Excellence in Diversity Award from the Regent for Tennessee.

Todd M. Willert, FACHE, CEO, Community HealthCare System, Onaga, Kan., received the Senior-Level Healthcare Executive Award from the Regent for Kansas.

Joyce E. Wood, FACHE, CNO/vice president, organizational improvement, Riverview Health, Noblesville, Ind., received the Senior-Level Healthcare Executive Award from the Regent for Indiana.

Want to submit?

Send your "Member Accolades" submission to he-editor@ache.org. Due to production lead times, entries must be received by Oct. 1 to be considered for the Jan/Feb issue.

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Communities, Forums and Networks

Enhance your membership through our multiple networking groups. Visit **ache.org/Membership** to learn more.

For individuals interested in the distinct opportunities and issues of Asian American healthcare executives.

Asian Healthcare Leaders Community

For members who wish to work toward enhancing representation of lesbian, gay, bisexual, and transgender healthcare executives and quality care for LGBTQ individuals.

LGBTQ Healthcare Leaders Community

For physicians currently in a management role or transitioning into one soon, connect directly with peers in real time to network, ask questions and share resources.

Physician Executives Community

This unique platform for healthcare consultants, at any level, offers the opportunity to advance skills and expertise, understand changing client needs, and grow business.

Healthcare Consultants Forum*

A community exclusively for CEOs to exchange ideas, share best practices and gain valuable resources to further support you in your endeavors.

CEO Circle*

This group requires an additional membership fee.

Engagement and Recognition

Members are making meaningful connections and being celebrated.

ACHE chapters are providing a mix of in-person and virtual events to their members, resulting in old relationships rekindled, new ones formed and achievements recognized. Below are examples of chapters providing value.

Spring Symposium in the Washington, D.C., Region
National Capital Healthcare Executives, George Mason University and Rising Healthcare Leaders at Mason hosted the 2022 Spring Symposium in Arlington, Va. This all-day, in-person event brought together healthcare leaders from across the Washington, D.C., metropolitan region for dynamic panel discussions about navigating leadership in our people-centered healthcare industry.

Chapter members, students and industry professionals made meaningful in-person connections, shared in thoughtful dialogue and participated in professional development. National Capital Healthcare Executives members also offered one-on-one resume review sessions during the event for graduate students in attendance preparing to enter the healthcare field.

Panelists and speakers representing some of the region's top healthcare organizations included the U.S. Army Corps of Engineers, Erickson Senior Living, Frederick Health, the U.S. Department of Health and Human Services, Inova Health System, the University of Maryland Medical Center and UVA Health. Topics covered crisis management, implicit bias and emotional intelligence in healthcare.

"It was great to bring together some of the outstanding healthcare leaders from our region during the Spring Symposium," says Dennis Grandic, director of programs, National Capital Healthcare Executives.

"We look forward to supporting our members' professional, educational and leadership needs by offering additional in-person educational and networking events through the rest of the year."

National Capital Healthcare Executives worked with Rising Healthcare Leaders at Mason for several months organizing and planning the event, which involved outreach, event promotion and navigating ever-changing safety protocols. The event reached capacity within three days of registration opening, with more than 120 people attending.

"After so much time apart since our last in-person event, it was evident our members were anxious to engage with one another," says John Budd, FACHE, president, National Capital Healthcare Executives. "For many of our members who were unable to travel for ACHE's Congress on Healthcare Leadership, this event was an impactful local alternative."

After the event, RHLM student leaders donated extra food from the symposium to local housing shelters.

ACHE of South Florida's Inaugural Chapter Appreciation and Recognition Event
ACHE of South Florida held its inaugural chapter appreciation and recognition event in May, its first in-person gathering of the year. About 200 people enjoyed a networking cocktail hour, musical entertainment, and a program that celebrated sponsors and members who have contributed to the chapter and the community.

"A dedicated event to formally recognize members who have shown their commitment to the organization and to appreciate our sponsors for the support that allows the board to bring chapter members educational, networking and special activities is important," says Oyinkansola "Bukky" Ogunrinde, president, ACHE of South Florida, and the first Black woman to lead the chapter. "I am honored to lead the first installment of this occasion, alongside the chapter's 2022 board of directors, the dedicated planning committee that produced the event and the volunteers who made the evening a success."

A high point of the evening was the keynote given by Aurelio M. Fernandez III, FACHE, former president/CEO, Memorial Healthcare System, Fort Lauderdale, Fla., and the recipient of the chapter's 2021

Healthcare and Community Impact Award. Fernandez, who retired in April, shared reflections of his professional career, imparted leadership lessons learned along the way and left the audience with the powerful advice to readily take on challenges and simply learn from any mistakes made. "You go for it. It doesn't matter if you fall, you can get up … and try again, but try it anyhow," he said.

"After not holding a chapterwide signature event in over two years, it was so rewarding being able to recognize so many members, sponsors and supporters that had contributed to our chapter's many successes in 2021," said Kenneth Wong, FACHE, the 2021 chapter president.

The event also celebrated student members who participated in the chapter's 2022 Annual Healthcare Leadership Case Competition. Florida International University took first place in the graduate division, and the University of Miami took first place in the undergraduate division.

Recipients of other awards presented included:

- 2021 Exceptional Service Award: Adrian Parker, FACHE.
- 2021 Leadership and Service Awards: Haroula Protopapadakis Norden, FACHE; Oyinkansola "Bukky" Ogunrinde; and Ralph Rios, FACHE.
- 2021 Regent Awards: Ayana J. Miller, FACHE; Rudy Molinet, RN, FACHE; and Cory P. Price, FACHE.
- Longest Consecutively Serving Active Board Member Honoree: Michelle F. Marsh.

- 2021 Chapter President Leadership Award: Kenneth Wong, FACHE.
- Chapter Regent Leadership and Service Award: Ashley R. Vertuno, FACHE.

"Being involved in ACHE has been a foundation for me throughout my career," says Ashley R. Vertuno, FACHE, past Regent for Florida—Eastern, and CEO, HCA Florida JFK North Hospital, West Palm Beach, Fla. "This event enhances our community of healthcare leaders coming together to build the future generations of leaders. I am proud and honored to have served. I hope that by receiving this recognition for my

service as Regent, I can continue to inspire other young professionals, particularly young women, to blaze their own paths in healthcare to positions of leadership and mentor them along the way, as others have done for me."

New Ways to Engage Members
The California Association of Healthcare Leaders is one of the largest ACHE chapters, serving more than 1,300 members in 50 of California's 58 counties. The incoming president, Michael O'Connell, FACHE, challenged the chapter's board of directors and committee members to consider exploring new and different ways to engage members with networking and

2022 ACHE-SFL board of directors—From left to right standing: Peter Christiaans; Adrian Parker, FACHE; Zunner Rios, FACHE; Niurka Diaz; Enrique Serrano; Haroula P. Norden, FACHE; David Morpeau; Mari Pantoja-Smith; Neil Mangus, FACHE; and Kenneth C. Wong, FACHE. From left to right sitting: Ralph Rios, FACHE; Marla Sanfilippo, FACHE; Jenna Merlucci, FACHE; Aurelio M. Fernandez III, FACHE; Oyinkansola "Bukky" Ogunrinde; Kristen Palanza; and Carlos H. Ayllon, FACHE.

2021 ACHE-SFL Board of Directors—From left to right: Adrian Parker, FACHE; Jenna Merlucci, FACHE; Ashley R. Vertuno, FACHE; Zunner Rios, FACHE; Kenneth C. Wong, FACHE; Oyinkansola "Bukky" Ogunrinde; Ayana Stephenson, FACHE; Mari Pantoja-Smith; Haroula P. Norden, FACHE; Kristen Palanza; Michelle Marsh; Charles Felix; and Marla Sanfilippo, FACHE.

educational opportunities. Based on a membership survey, respondents said they were feeling disengaged after two years of the pandemic and wanted to connect with other members in new and meaningful ways. Members wanted events that allowed them to learn from one another, share their insights and perspectives, and get to know other chapter members on both a personal and professional basis.

In response, the chapter began offering one-hour free virtual networking sessions. Participants, without the aid of presenters or subject-matter experts, discussed current and relevant topics. Some members said this was the first time they had joined a chapter event, and others expressed appreciation for hearing new perspectives.

Working toward the goal of having every member of the California Association of Healthcare Leaders connecting with other ACHE members in at least one networking or educational event in 2022, chapter leaders had to think and act differently in their approach to expanding virtual access to such opportunities. The chapter contacted other chapters to see if they wanted to co-sponsor virtual events. Since reaching out, the California Association of Healthcare Leaders is now co-sponsoring events with four other chapters. This new opportunity has expanded offerings to more members and has forged new relationships and partnerships.

The chapter's leadership learned a lot during the pandemic about creating new ways to help its members stay engaged. It also learned it's critical to continuing listening to members, responding to their educational and networking needs, and expanding its offerings. ▲

*To find your chapter or search the chapter directory, go to **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.*

2022 ACHE-SFL Chapter President Oyinkansola "Bukky" Ogunrinde presents the Healthcare and Community Impact Award to Aurelio M. Fernandez III, FACHE.

Attendees mingle during the inaugural ACHE-SFL Annual Chapter Appreciation and Recognition Event networking reception.

ETHICAL POLICY STATEMENT

Considerations for Healthcare Executive-Supplier Interactions

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

Statement of the Issue

Healthcare executives share a fundamental commitment to improve the cost, quality and outcomes of care and to create an equitable, effective, safe and efficient healthcare delivery system for those needing healthcare services. To accomplish these fundamental objectives, healthcare executives must rely on an intricate network of professionals that includes professionals within the supplier community.

The realm of healthcare executive-supplier relationships involves both the purchase of goods and services and the mutual provision of information and advice that facilitates the informed decision-making for the benefit of patients and organizations.

In interacting with current and potential suppliers, healthcare executives must act in ways that merit trust, confidence and respect, while fulfilling their duties to the public, their organizations and the profession. Further, it is important to avoid even the appearance of conflicts of interest that may seem to unduly advantage the healthcare executive, the organization or the supplier. Thus, healthcare executives must demonstrate the utmost integrity and embrace the need for transparency in interactions with suppliers.

Policy Position

The American College of Healthcare Executives believes that healthcare executives may interact with company representatives who sell products and services to their organizations in a way that:

- Advances patient care or improves healthcare delivery.

- Is fully disclosed to and reviewed by the executive's organization.

- Does not damage the reputation of the organization, the healthcare executive or the profession.

- Does not violate policies of the executive's organization.

- Does not violate applicable law.

In determining whether the nature of specific executive-supplier interactions meets each of the above guidelines, organizations should have an established mechanism to review the appropriateness of such relationships to ensure that a potential conflict of interest is avoided. The mechanism should carefully consider the issues detailed below.

1. The interaction between an executive and a supplier should enhance patient care or improve healthcare delivery when one or more of the following conditions are evident:

   - It furthers the executive's knowledge of products or services that may improve patient care or health system operations.

Considerations for Healthcare Executive-Supplier Interactions

(Cont.)

- It furthers the supplier's knowledge of the specific needs of, or challenges facing, the executive's health system, and enables the supplier to propose options for consideration and/or produce improved, revised or updated products and services.

- It facilitates the efficient and cost-effective delivery of products and services to the executive's organization.

- Examples of reasonable interactions that could enhance patient care, improve healthcare delivery or health system operations are attendance by executives at trade show exhibits of supplier products or seminars or demonstrations produced by suppliers.

2. Full disclosure and review of the supplier-executive relationship to the executive's organization should be made to the party within the organization to whom the executive reports and through the organization's compliance program officer and/or conflicts committees. To prevent misunderstanding, it is advisable that disclosure include all remuneration arrangements. Organizations should have clear guidelines regarding whether the acceptance of any reimbursement and/or gifts for the executive's interactions with suppliers is acceptable.

3. Even with full disclosure and review, damage to the reputation of the executive, the organization or the profession may occur. The executive should avoid interactions with suppliers when this risk is present or perceived.

   - Executives should avoid interaction with suppliers that could result in undue influence by suppliers in the decision-making process.

   - As with any position of public trust, avoiding even the appearance of wrongdoing, conflict of interest or interference with free competition is important. Executives should take care that interactions with suppliers not result in

perceptions of undue influence or other perceived impropriety.

4. Healthcare executives are subject to the federal anti-kickback statute, which makes it a criminal offense to knowingly and willfully offer, pay for, solicit or receive any remuneration to induce referrals of items or services reimbursable by federal healthcare programs.

   - The anti-kickback statute interprets remuneration very broadly, including the transfer of anything of value, in cash or in kind, directly or indirectly, covertly or overtly.

   - The anti-kickback statute provides a basis to prosecute if an executive receives any remuneration in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under a federal healthcare program.

   - The Patient Protection and Affordable Care Act clarified that each violation of the anti-kickback statue was also a violation of the False Claims Act.

   - The healthcare executive should be aware that other statutes, which may vary from state to state, may also be applicable. If the application of a law to a proposed interaction is unclear, the executive has a duty to seek guidance from the appropriate party, who may be the person to whom the executive reports or the organization's legal counsel.

5. In addition to applicable laws, healthcare executives have a duty to be familiar and comply with their organizational policies governing interaction with suppliers. If the application of an organization's policy to a proposed interaction is unclear, the executive has a duty to seek guidance from the appropriate party, who may be the person to whom the executive reports, the organization's legal counsel, compliance officer or ethics adviser.

Executive-supplier relationships may raise significant questions. The context and nature of the relationship can be more significant than the specific setting or type of interaction. Therefore, in addition to the above criteria, there are a number of questions healthcare executives and their organizations should consider when assessing the nature of arrangements with suppliers and evaluating if a real or perceived conflict of interest is likely:

- Will the relationship affect your professional judgment, the judgment of your colleagues or the organization?

- Who will benefit from the relationship? Who might suffer?

- Would you be comfortable with the relationship if it were known to your patients, stakeholders and the general public?

- Can you defend the relationship to your colleagues and superiors?

- Does it represent a positive model for managerial, professional or organizational behavior?

- Does the relationship potentially represent a conflict of interest or other adverse situation because of other parties involved?

- Would you expect other organizations or individuals to behave similarly?

- Is it fair to all parties?

When considering these questions, the healthcare executive should be cognizant of the need for public trust and the avoidance of even the appearance of impropriety.

Furthermore, to foster knowledge and sensitivity to potential issues associated with supplier interactions, healthcare executives should promote the dissemination of this Policy Statement to appropriate managers within their organizations and to relevant suppliers.

Policy created: November 2007
Last revised: November 2016

Self-Awareness: The Underappreciated Superpower of Effective Healthcare Leaders

Many successful clinicians struggle in leadership roles. The same is true of promising administrators who take on management responsibilities. Why do clinical skill and technical knowledge fail to translate into effective leadership? The problem is often a lack of self-awareness.

Without self-awareness, you will never realize your full potential as a leader. Essentially, you will not see the weaknesses that are holding you back, and you will not understand the strengths that could drive your success. Here are three ways to cultivate self-awareness.

1. Step Away From the Mirror and Open a Window

For some people, self-awareness connotes gazing in a mirror. But the mirror view is incomplete. To be truly self-aware, you need to see yourself through the eyes of others. Getting an outside perspective is the only way to identify the habits that undermine your leadership efforts.

The most effective tool for gaining an outside perspective is a 360-degree feedback assessment. Structured feedback from colleagues, direct reports, supervisors and others will illuminate both your weaknesses and your strengths. The process is challenging, but the self-awareness you gain from it will help you work with others more effectively.

2. Realize Who You Are Feeding

A question to ask yourself in becoming self-aware is what is your motivation in leading? Is it to accomplish a goal in collaboration with others? Or is it to feel good about yourself by receiving respect? For most people, the honest answer is a combination of both. The main point is that to the extent you focus on feeding your ego, you will not be serving the needs of others.

The issue of motivation becomes very important when it comes to building consensus. Executives whose main drive is to be liked will tend to tell everyone what they want to hear. While openness is important, mere agreeableness leads nowhere.

The key is self-awareness. Effective leaders understand their own convictions and act from their true values. This enables them to find common ground with others and build a durable foundation for organizational change.

3. Understand the "Life Script" That Is Driving You

Life scripts are basic patterns of thought and action. Many people are familiar with *introversion* versus *extroversion*, but there are many similar patterns. There is no "right" script; however, unconscious life scripts can limit your ability to work with others.

For example, say that the executive team at a community hospital is considering a proposal to launch a new program based on an innovative therapy. Leaders with a risk-tolerant life script want to dive in immediately, saying "This is cutting-edge" or "This will save lives." Leaders with a risk-averse script want to hold back, saying "This costs too much" or "The science is uncertain."

The proposal in question may or may not be a good idea; the key is to debate the real issues, not wrangle over opposing life scripts. Self-awareness helps you understand your personal patterns so you can work with others to make effective leadership decisions.

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