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This Issue:

Green Lessons From
Other Industries

Rethinking Community
Benefit Reporting

Congress
Wrap-Up

HEALTHCARE EXECUTIVE

The MAGAZINE FOR HEALTHCARE LEADERS

VOLUME 24, NUMBER 3 • MAY/JUNE 2009

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Responding to the
Sustainability
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THE RIGHT LEADER
FOR YOUR ORGANIZATION?**

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Kay A. Branz

Eco-Friendly Hospitals

Evidence of global warming, increasing energy prices and heightened public awareness are just some of the catalysts for the growing sustainability wave. In “Beyond the Bin: How Healthcare Is Responding to the Sustainability Movement” (pages 8–19) Deborah Popely talks to leading healthcare executives who are transforming their organizations.

“Looking Out for Inspiration: What Healthcare Can Learn About Green From Other Industries” (pages 20–28), by John M. Buell, gives a summary of an ACHE program held in Orlando, Fla., in December. Titled “Healthcare Going ‘Green’: The Business of Environmental Sustainability” and funded in part by ACHE’s Fund for Innovation in Healthcare Leadership, the program featured ideas and green success stories from the hospitality, finance and education industries and insight from healthcare organizations already making sustainability a priority.

“Rethinking Community Benefit Reporting: A Strategic View to a Stronger Commitment” (pages 32–38), by Susan Birk, encourages healthcare leaders to take stock of their community benefit initiatives to determine if resources are being used optimally to achieve meaningful and lasting improvements in community health.

Also in This Issue

Check out the responses to our CEO survey on green initiatives in healthcare (pages 93–94). In addition, highlights of ACHE’s 52nd Congress on Healthcare Leadership can be found on pages 40–50 and in “Meeting Highlights” on page 95. Mark your calendars now for the 2010 Congress on Healthcare Leadership, March 22–25 in Chicago. ▲

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Thomas C. Dolan, PhD,
FACHE, CAE

We Make the Difference

Healthcare executives play key role in ensuring patient safety and quality of care.

When I was trained in healthcare management in the early 1970s, we knew the hospital's board was ultimately responsible for the quality of care provided and that as healthcare executives we had an important role to play. We also believed it was the primary responsibility of the medical staff to ensure that quality.

All that changed in 1999 when the Institute of Medicine (IOM) issued its landmark report *To Err Is Human: Building a Safer Health System*.

Many of us did not want to believe the magnitude of medical errors cited in that famous report. But the data clearly indicated a problem and not one that was simply caused by a few bad apples. The report concluded that errors are commonly caused by "faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them ... Thus, mistakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right."

The IOM's report made it obvious that healthcare executives had to do more to ensure quality and patient safety in our nation's hospitals. Assisted by organizations such as the

Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement and the Joint Commission, healthcare executives have made real progress, but we can do more.

This is one reason why ACHE's Board of Governors approved a new Policy Statement at its November 2008 board meeting: "The Healthcare Executive's Role in Ensuring Quality and Patient Safety." While the Policy Statement lists a number of steps healthcare executives can take to help ensure quality and patient safety in their organizations, the four listed below are perhaps the most critical:

1. Equip the board. We should equip our boards with the tools and information they need to provide appropriate oversight of the organization's patient safety/quality strategy. The establishment and review of improvement goals and quality/safety indicators should be regular components of every hospital board's agenda.

2. Involve the executive leadership team. There is ample evidence that when a hospital's CEO commits to quality and patient safety, the organization's performance on these two fronts improves. The CEO, together with the rest of the senior leadership team, should establish and monitor

an executable strategy for setting and achieving safety and quality goals. It should include clearly defined metrics for tracking progress.

3. Engage medical staff. Patient safety and quality strategies, implementation plans and metrics should be developed with the meaningful involvement of the organization's medical staff. This should be done in a manner that effectively and efficiently uses the medical staff's time and expertise.

4. Listen to patients and their families. Creating a patient-centered culture has been shown to improve outcomes and patient satisfaction while reducing errors and costs. Hospitals should develop processes to ensure the voices of patients and their families are heard, and their input should be included in the design and improvement of care processes.

There are a number of other strategies healthcare executives can employ to improve patient safety and quality of care, which can be found in the complete Policy Statement in the March/April 2009 issue of *Healthcare Executive* and in the Policy Statements area on ache.org.

Quality and patient safety are everybody's responsibility in our healthcare organizations, but they are especially the responsibility of those of us in leadership roles. Making a strong commitment to these goals is another way to show we are leaders who care. ▲

Thomas C. Dolan, PhD, FACHE, CAE, is president and chief executive officer of the American College of Healthcare Executives. He can be reached at tdolan@ache.org.



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BEYOND THE BIN

How Healthcare Is Responding to the Sustainability Movement

By Deborah Popely

Acting on the ethical imperative “First do no harm,” healthcare organizations throughout the United States are viewing environmental sustainability as an extension of their mission to promote the health and well-being of the community.

“Healthcare hasn’t been at the forefront of the green movement, although there have been some early adopters,” says Bob Eisenman, executive director of the Global Health and Safety Initiative (GHSI), an effort initiated by the nation’s largest health systems to address healthcare’s environmental footprint. “Now healthcare leaders are increasingly asking, ‘What should I do?’ and ‘What will it cost?’”

Hospitals are among the largest users of energy and water and generate tons of solid and medical waste that can expose patients, staff and community residents to toxins and pollution. As large emitters of carbon dioxide (CO₂), hospitals also contribute to global warming, which has been linked to weather-related disasters and outbreaks of disease.



“As a Catholic healthcare institution, we have had a long-standing commitment to environmental stewardship,” says Robert Henkel, FACHE, COO of Ascension Health System, St. Louis. “There is no doubt, however, that media attention, rising public expectations and a new president with a strong environmental agenda (are) helping propel this movement forward.”

According to Bob Jarboe, executive director of the nonprofit advocacy organization Practice Greenhealth, “The hospital, in essence, can situate itself in the broader ecology of its community and region and act as a healing force.”

Adds Henkel, “For us, it’s about creating healthier communities.”

A Profitable Investment

There is growing evidence that greener facilities improve patient outcomes, decrease lengths of stay and improve the health and performance of staff, while saving money and minimizing liability and compliance risks.



EASY GREEN IDEAS

- 🌱 Switch from Styrofoam and other disposables to china, drinking glasses and coffee cups in the cafeteria.
- 🌱 Adopt reusable sharps containers.
- 🌱 Replace blue wrap with reusable sterilization cases.
- 🌱 Eliminate plastic bags from health fairs.
- 🌱 Provide reusable canvas bags for patient belongings.
- 🌱 Decrease paper use—more PowerPoint and two-sided printing.
- 🌱 Use rechargeable batteries.
- 🌱 Eliminate mercury.
- 🌱 Reprocess single-use devices.
- 🌱 Recycle paper, aluminum and cardboard.
- 🌱 Collect old cell phones, computers and components for recycling.
- 🌱 Retrofit lighting with more energy-efficient bulbs.
- 🌱 Switch to green cleaners.
- 🌱 Start a carpooling program.
- 🌱 Provide bikes for employee errands.

“Sustainability is an extension of our mission to provide the highest level of personalized care,” says Daniel E. Neufelder, FACHE, president and CEO of Affinity Health System, Appleton, Wis. “Our data show the highest patient satisfaction and lowest staff and physician turnover occur in our green facilities.”

Daylight and improved indoor air quality also have an impact on employee health and productivity, yielding a 2 to 16 percent increase in worker and student productivity, according to internal data from the U.S. Green Building Council (USGBC), a leading environmental

training and certification, non-profit organization.

In addition, going green can offer a competitive advantage. Parrish Medical Center, Port St. John, Fla., is a Leadership in Energy and Environmental Design (LEED)-certified diagnostic treatment center on a 33-acre site that includes a four-acre nature preserve to appeal to a younger, more environmentally conscious demographic. “We have captured tremendous market share in this community because we have built a project consistent (with) and reflective of the community in which it is located,” says George

Mikitarian Jr., FACHE, president and CEO of Parrish.

Getting Over the “Cost” Hurdle

“There are some real costs involved in making these changes, but the return on investment can be substantial,” says Ascension Health’s Henkel.

“The conventional wisdom is that green building costs more,” says Julie Schaffner, FACHE, COO of Advocate Lutheran General Hospital, Park Ridge, Ill., which is in the process of building its \$200 million Gold LEED bed tower. “But in reality it is less expensive if you look at the cost over the life of the project.”

Adds David R. Lincoln, FACHE, president and CEO of Covenant Health Systems, Lexington, Mass., “It is important to educate people in your organization. You have to present them with facts and figures and give them the opportunity to raise objections and concerns.”

Skeptics can be convinced, Lincoln says, by “focusing on taking small steps, doing things that objectively work and going after the low-hanging fruit. We try to take a balanced approach, continuing to make advances but being realistic about what we can and cannot do right now. We count pennies and make it work.”

Eliminating bottled water is an example of this type of change. “Two or three years ago, we replaced bottled water with pitchers and tap water



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at all our meetings,” says Ascension Health’s Henkel. “Not only does it conserve water and reduce the demand for plastic, it actually saves us a lot of money each year.”

Many Routes to Sustainability

Sustainability is defined as “meeting present needs without compromising the ability of future generations to meet their needs,” according to the World Commission on Environment and Development (WCED), which was convened by the United Nations in the 1980s. How healthcare organizations go about achieving that goal varies, but much of the current activity falls into the following areas:

Green Building and Renovation

Green building is one of the most visible manifestations of the green healthcare movement, particularly as hospitals replace or rebuild decaying facilities to accommodate the needs of aging baby boomers. Eileen Secrest, director of communication for Practice Greenhealth, says the building boom has slowed in response to the recent economic downturn, “but there are many projects planned—many of them with sustainable features—that are waiting on funding.”

The Green Guide for Health Care (GGHC), a project of the nonprofit Center for Maximum Potential Building Systems (CMPBS) and Health Care Without Harm, is generally viewed as the green building and operations Bible for the healthcare

sector. According to CMPBS Chair Gail Vittori, the *GGHC* was initiated in 2002 to “help jumpstart the process of establishing a green standard for healthcare at a time when there was a void in the marketplace.” To date, more than 160 U.S. projects have self-certified with the *GGHC*. In addition, more than 22,000 individuals subscribe to the *GGHC* Web site for updates and guidance on green building and operations.

According to Vittori, some healthcare green building initiatives seek certification with the USGBC’s LEED Rating System, often in addition to self-certification through the *GGHC*,

in order to obtain independent third-party validation. Each of the healthcare providers interviewed for this article has one or more green building projects under way and most involve LEED certification. The USGBC is in the process of developing a new standard to meet the specific needs of the healthcare market and expects to release it in 2009.

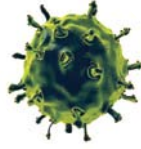
Recycling and Waste Reduction

“Cleveland Clinic has a responsibility to create and maintain programs that contribute to improvements in our environment,” says Delos (Toby) M. Cosgrove, MD, FACHE, president and CEO of Cleveland Clinic. “By



Photo courtesy of Seton Family of Hospitals (Ascension Health System)

Dell Children’s Hospital in Austin, Texas, is the world’s first Platinum LEED hospital. The design conserves water and electricity, improves air quality, reduces pollutants and allows sunlight to reach 80 percent of the available space. A 4.3-megawatt, natural gas-fired power plant produces 100 percent of the hospital’s electricity, heating and cooling.



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SNAPSHOT OF GREEN HEALTHCARE PRACTICES

In fall 2008, Practice Greenhealth surveyed its members about current and future green initiatives. More than 50* hospitals and health systems from 22 states and Ontario responded to the survey.

Findings include:

WASTE REDUCTION Sixty-one percent had implemented a waste-reduction plan, and 30 percent were in the planning process.

RECYCLING Thirty-three percent of respondents recycle at least 20 percent of their facility's waste.

ENVIRONMENTALLY PREFERABLE PURCHASING Ninety-three percent have or are in the process of implementing an environmentally preferable purchasing (EPP) program.

ENERGY Ninety-three percent have made efforts to increase energy efficiency. Seven facilities report generating renewable energy on-site. Four facilities report using renewable energy to supply 3 to 17 percent of their overall energy use.

SUSTAINABILITY LEADERSHIP Seventy-nine percent have or are planning to designate an individual to lead sustainable activities. Eighty-nine percent have a green team or use an existing committee.

SAVED MONEY AS A RESULT Sixty-eight percent report saving money as a result of sustainable initiatives. Thirteen respondents reported saving from \$10,000 to \$2 million.

processed and redeployed. We also replaced disposable blue wrap with reusable metal sterilization cases."

Cleveland Clinic also has worked out a take-back arrangement with its IT vendor to reduce e-waste and has initiated a program for reusing furniture within its system, "which saves us a significant amount of money," says Ayers.

Purchasing and Supply Chain

Most green healthcare initiatives include efforts to purchase environmentally preferable equipment, medical supplies and chemicals that minimize patient risk, protect employee health and limit any negative impacts on the surrounding community. For example, Advocate recently switched to DEHP-free tubing to protect male newborns in the intensive care unit. "We try to influence our vendors to develop products that meet higher standards of sustainability," says Advocate's Schaffner.

Mercury Free

Sustainability leader Kaiser Permanente pioneered the use of mercury-free thermometers, and now dozens of healthcare institutions are partially or fully mercury free. Affinity Health System is among more than 20 healthcare organizations recognized by Practice Greenhealth with its Making Medicine Mercury Free and Environmental Leadership Awards. "It took us a couple of years to work our way through the process. We had

* Total responses varied from 53 to 58 depending on the question. Percentages are based on total responses to particular questions.

expanding our recycling program and exploring other sustainable efforts, we hope to do our part for future generations." As a result of its efforts, Cleveland Clinic increased waste diversion to 15 percent in 2008, up from 9 percent in 2007, and expects another increase in 2009.

"The first step is to get a handle on your waste and see where you can cull materials from what's typically disposed of," says Christina Ayers, Cleveland Clinic's first director of its new Office for Healthy Environments. "For example, we switched to reusable sharps receptacles, which are

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Advocate Lutheran General Hospital's Bed Tower in Park Ridge, Ill., will be the state's first healthcare facility to achieve Gold LEED certification. Sustainable features include a special meditation garden (pictured above) along with a green roof; rain gardens; ultra-energy-efficient mechanical and electrical systems; recycled, locally produced and rapidly renewable materials; and a green building visitor center.

to switch out blood pressure devices, look at the central plant and rebalast lamps, among other efforts," says Gary Kusnierz, vice president, performance excellence, for Affinity.

Healthy Food

Healthcare providers serve thousands of meals each day to patients, staff and visitors. Cleveland Clinic has taken a unique approach to reducing the impact on the food system by establishing several "micro-farms" on 1.8 acres of vacant property. It then launched a farmer's market, which provides an outlet for these growers along with 30 to 40 other local farmers. "In addition to increasing the amount of locally

grown food served in our cafeterias, the program benefits employees, patients, community residents and the local economy," says Cleveland Clinic's Ayers. "We have an agreement to buy any leftover food for our cafeterias, but most of the time there is nothing left to buy."

Energy Efficiency

According to the U.S. Environmental Protection Agency's Energy Star program, healthcare organizations spend more than \$8.3 billion on energy each year to meet patient needs. More than 6,000 buildings in the United States have earned the Energy Star certification, of which 80 are healthcare facilities. Energy Star buildings on average use 40 percent less energy and produce 35 percent less carbon dioxide. Ascension Health's Henkel has documented an annual savings of \$900,000 across the system as a result of participation by 66 of the organization's 70 facilities in the Energy Star program.

Other health organizations are exploring the use of wind, biomass, natural gas and other alternative energy sources. Covenant Health Systems was one of the first healthcare organizations to participate in the Healthcare Clean Energy Exchange, a reverse auction program recently initiated by Practice Greenhealth and Premier Inc. Through this program, energy providers compete to supply

- RESOURCES** Practice Greenhealth: www.practicegreenhealth.org
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The Green Guide for Health Care: www.gghc.com
Healthcare Without Harm: www.noharm.org
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Christina Vernon Ayers, AIA, LEED AP, Director, Office for a Healthy Environment, Cleveland Clinic.



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Measuring and Mitigating Carbon

One of the biggest challenges is accurately measuring greenhouse gas emissions and creating a portfolio for systematically reducing CO₂. Part of the impetus behind GHSI is "working with the new administration and green healthcare groups to create a common template and framework for quantifying environmental impact and savings," says Ascension Health's Henkel, who is also GHSI's chairman.

This year, Practice Greenhealth launched a new Web-based tool to calculate the public health impact and costs of electricity consumed by U.S. health facilities generated from nonrenewable fossil fuel. The Healthcare Clean Energy Exchange Energy Impact Calculator calculates sulfur dioxide, nitrogen oxide, CO₂ and mercury emissions based on kilowatt use by the facility and the fuel mix of the relevant power grid.

These efforts are just the tip of the iceberg. Healthcare organizations also are working on issues such as water conservation, reduction of hazardous medical waste and donation of unused medical supplies to needy communities. All are helping healthcare move beyond the bin to a more sustainable future.

Deborah Popely is a freelance writer based in Des Plaines, Ill.

10 STEPS TO GREENING SUCCESS

The following steps can start you on the path toward a cleaner and greener healthcare organization:

1. Obtain Senior Management Commitment and Support

One thing successful green initiatives have in common is leadership and support from senior management. “We had a CEO champion who set us on a sustainable course,” says Julie Schaffner, FACHE, COO of Advocate Lutheran General Hospital, Park Ridge, Ill. “You need top-level support and passionate people at all levels of the organization.”

2. Make It Part of Your Mission and Vision

Covenant Health Systems’ environmental mission and vision emerged from its 2004 strategic planning process. “The program now has a life unto itself and will be a major factor in our 2010–2012 strategic plan,” says David R. Lincoln, FACHE, president and CEO of Covenant Health Systems, Lexington, Mass.

3. Convene a Green Team

Advocate Lutheran General’s Schaffner advises recruiting a green team of interested individuals from all levels and functions within the organization. Ascension Health has established point persons in 70 facilities in 20 states and districts who interface with a larger “green council” on a monthly basis.

4. Establish Coordination and Accountability

Sustainability manager positions are being created to coordinate larger and more complicated programs. Cleveland Clinic’s director, Office for Health Environments, filled by Christina Ayers—a LEED-accredited architect—is a good example of the trend. Practice Greenhealth recently started a training program to help nonspecialists obtain the technical knowledge and support they need.

5. Establish a Baseline

“An important initial step is assessing where you are and what you are already doing, taking the good things that are going on and sharing best practices across the organization,” says Covenant’s Lincoln.

6. Develop Green Purchasing Standards

According to Practice Greenhealth, an environmentally preferable purchasing program “looks upstream at what is coming in the front door versus just handling waste and toxic substance at the back door.” The organization advises establishing a list of preferable products that meet clear standards, keeping environmental impacts in mind.

7. Establish a Green Building Policy

It is important to have a policy to ensure all construction and renovation meets sustainability standards. “Our green building policy will be incorporated into our capital project review process, making green building the norm and ‘non-green’ the exception,” says Lincoln.

8. Educate and Engage Employees

Cleveland Clinic’s green program has a robust internal Web site, an employee communication team and a recognition program that “helps maintain enthusiasm and improves compliance,” says Ayers.

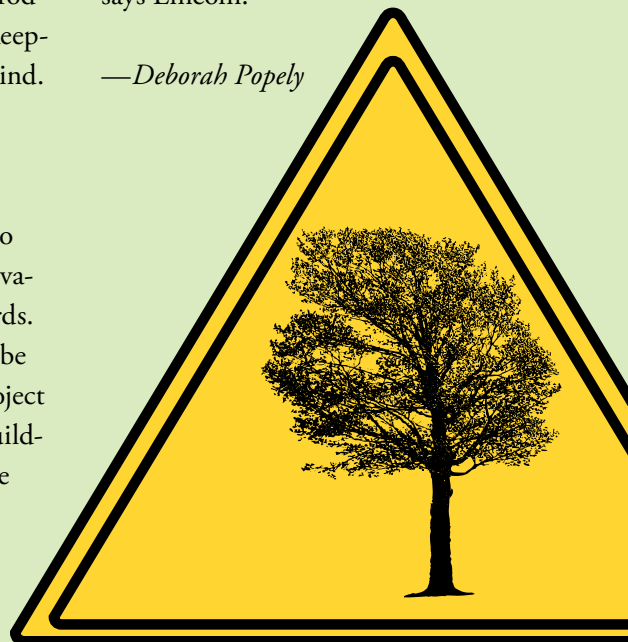
9. Establish Performance Metrics and Evaluate Annually

Affinity Health Care has established a framework that combines Lean production processes and research with its sustainability goals. “Our framework brings rigor to the process. For instance, we monitor utility costs on each facility on an annual basis and have found an 18 to 20 percent reduction,” says Gary Kusnierz, vice president, performance excellence, Affinity Health System, Appleton, Wis.

10. Celebrate Success

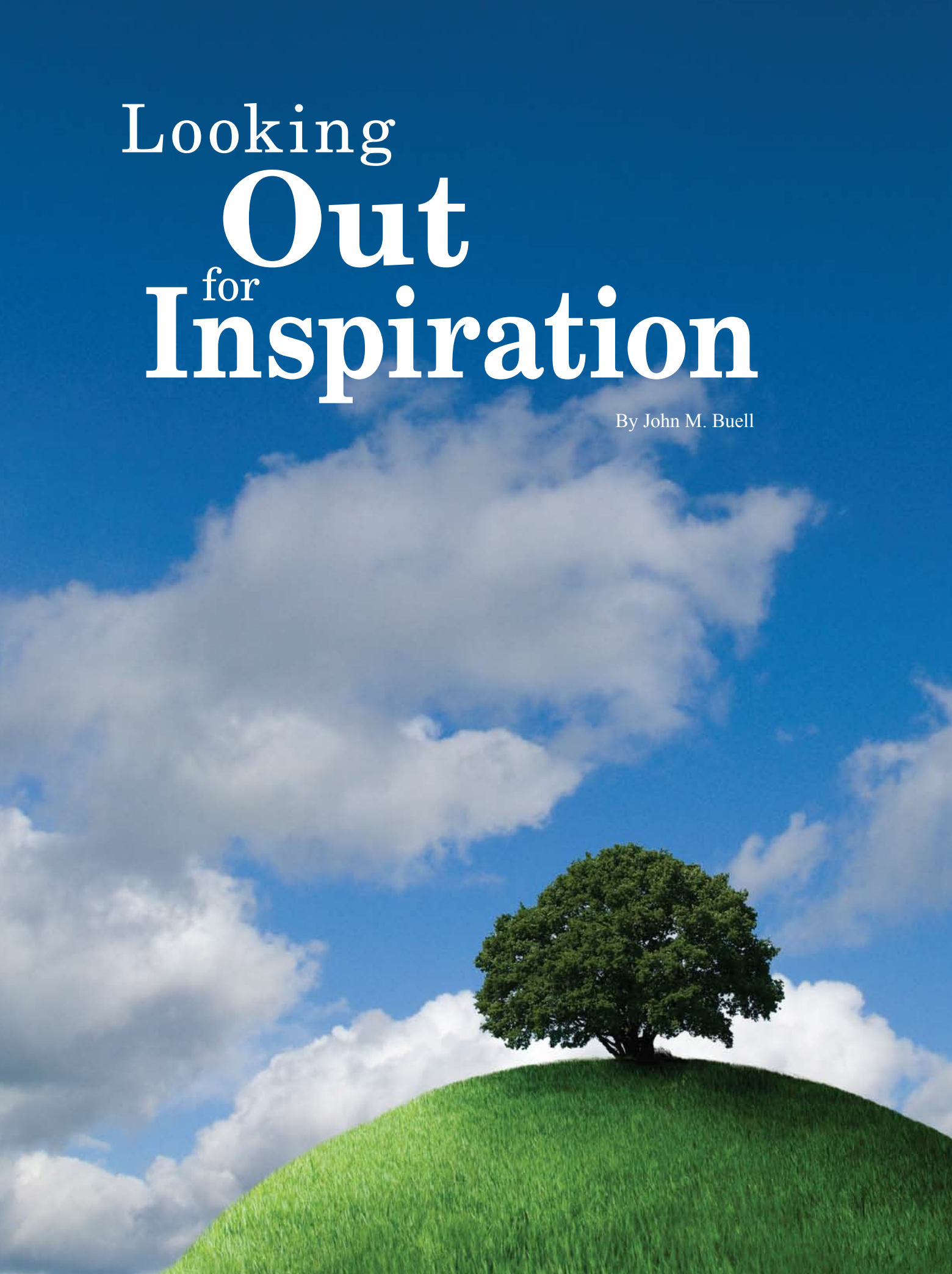
Share achievements and awards with staff and community. “We do Earth Day in a big way, with banners, posters as well as staff and community activities, which helps make sustainability part of our everyday culture,” says Lincoln.

—Deborah Popely



Looking Out for Inspiration

By John M. Buell



What healthcare can learn about green from other industries

Healthcare executives are uniquely placed to foster healing of the planet along with their primary mission of healing people. And when it comes to the planet, healthcare leaders can learn a lot by looking beyond their field and tapping the experience of organizations in other industries that have launched successful sustainability efforts.

Environmental inroads have been made in the hospitality, finance and education industries, which share similar operations to healthcare and offer a wealth of inspiration for healthcare organizations pursuing green efforts. Hotels, like healthcare organizations, operate round the clock, maintain beds for many guests, employ housekeeping staff and provide food service. And financial and educational institutions have multiple locations. Healthcare executives are rightly interested in discovering how environmentally positive improvements in these areas and others may apply to the healthcare setting.

This “cross-border” sharing of ideas and inspiration was the focus of “Healthcare Going ‘Green’: The

Business of Environmental Sustainability.” The program, held in Orlando, Fla., in December, was presented by the American College of Healthcare Executives (ACHE) and funded in part by ACHE’s philanthropic initiative, the Fund for Innovation in Healthcare Leadership. (See “Fund for Innovation in Healthcare Leadership,” page 26.) Executives gathered to hear from their colleagues and representatives of Marriott, JPMorgan Chase and the State University System of Florida. Clark Reed, director, Healthcare Facilities Division of Energy Star, U.S. Environmental Protection Agency, Washington, D.C., was the keynote speaker and moderated the event.

Each nonhealthcare organization provided insight on how it is reducing its water and energy consumption, two key areas of interest for healthcare leaders. Representatives from three hospitals also presented. (See sidebar on page 23.)

Sustainability in Hospitality

Of the industries represented, hotels most closely mirror hospitals in their

round-the-clock operations and demands: “We have lots of beds and you have lots beds,” said presenter Leslie Wright, director of sales and marketing with Marriott. Wright, who works for one of Marriott’s hotels in

its global operations and measuring its environmental impact. What it learned was an eye opener for the hotel chain: Its carbon footprint was 3 million metric tons, or 69.5 pounds per available room per night.

“When they get in the comfort of their guest room and are lying in bed, the last thing they want to do is get up and throw their recyclable away in the bin in the bathroom,” she said. “We are trying to manage that piece of it because it’s a huge expense to put two recycle bins in each room.”

Though some recycling efforts are more difficult for guests to follow than others, said Wright, it is smart business long term and good for the planet. “Ninety-five percent of our guests expect us to undertake green initiatives,” she said. “Sustainability is a competitive advantage.”

The other piece of Marriott’s recycling program is to ensure housekeeping staff separate recyclable trash from nonrecyclable garbage. “Getting their buy-in didn’t happen overnight,” said Wright. But after attending training sessions, Marriott’s housekeeping vendor eventually understood the importance of recycling and its role in it.

The Spirit to Preserve program also examined Marriott’s \$10 billion a year supply chain to work with its top vendors to have them supply more price-neutral, green products. The initiative includes:

- Replacing 24 million plastic key-cards with cards that contain 50 percent recycled material. This will save 66 tons of plastic from entering landfills.

“Ninety-five percent of our guests expect us to undertake green initiatives. Sustainability is a competitive advantage.”

—Leslie Wright, director of sales and marketing, Marriott

Minneapolis, participates in Marriott’s Green Council for the Central Region, which develops and communicates its “green” message to all Marriott clients and hotels nationwide.

Marriott’s sustainability efforts are built on a long track record of social responsibility and energy conservation dating back 30 years. In 2008 it launched a new initiative, Spirit to Preserve, aimed at reducing its 3,000 hotels’ environmental impact and saving money.

Spirit to Preserve differs from traditional hotel environmental initiatives in that it takes into account guests who use its hotels, in addition to focusing on housekeeping, engineering and operations, according to Wright.

“We wanted to get a sales perspective on how to make this work operationally and how we can keep the best interests of the customer in mind,” she said.

In 2008 Marriott began the process of understanding and reducing its total carbon footprint by reviewing

To ensure it measured its carbon footprint correctly, Marriott certified the results with an independent third party, energy management consulting firm ICF International, Fairfax, Va. It then recorded the results with the Carbon Disclosure Project (CDP), an independent nonprofit organization that holds a database of corporate climate change information. CDP is a leader in carbon disclosure methodology and process, providing primary climate change data to the global market place.

Comfortable that its carbon footprint measurements were accurate, Marriott identified areas for reduction. It also kept in mind its guests’ impact on the environment and how they could play a part to reduce it. At Marriott’s Minneapolis hotel, for example, small but significant environmental sustainability steps were taken. They included placing recycle bins in the lobby and two in each of the more than 290 rooms. Guests use the bins in the lobby, but it’s been a harder push to get them to use the bins in their room, according to Wright.

Opportunity to Learn, Share Ideas

"Healthcare Going 'Green': The Business of Environmental Sustainability" provided attendees with an occasion to debate and challenge healthcare's old ways of doing things.

Most hospitals don't undertake "green" initiatives because of competing priorities, said George Hayes, FACHE, president and CEO, Medical Center of the Rockies, Loveland, Colo., which recently built a green hospital and is undergoing LEED certification.

Hayes, who presented at the session, said hospitals and health systems are capital intensive and find it difficult to see the return on investment (ROI) and benefit to patient care of purchasing a new heating and cooling system instead of an MRI. Both have competing priorities but both also have patient relevance.

Ken Haber, vice president, Support Services, NewYork-Presbyterian Hospital, New York, N.Y., agreed. Haber, who also presented at the session, said healthcare executives need a mentality of sustainability in everything they do and to not view going green as a project that competes with capital equipment for funds.

"You shouldn't be making decisions unless you are considering the impact on what you are about today and the future—then you get away from that competing priority situation," he said.

Presenter George Mikitarian Jr., FACHE, president and CEO of Parrish Medical Center, Titusville, Fla. (its Port St. John facility is Florida's first silver LEED-certified outpatient facility), said sustainability is a worldwide issue, not

just one for healthcare. Eventually, hospitals will have to address their sustainability plan.

"For whatever reason you want to adopt the philosophy of going green, you are going to be forced into it in one way, shape or form," he said. "And when we get to that point, it (green) will move up the priority list."

Many attendees said the session demonstrated the value of implementing sustainability programs in their own organizations.

John A. Fischer Jr., FACHE, senior vice president, Hospital Operations, Phoebe Putney Memorial Hospital, Albany, Ga., attended the session with the goal of gathering green ideas for a new hospice center and hospital under construction and came away so impressed that he convinced his organization to pursue LEED certification.

"I was charged up when I returned to work," says Fischer, who was interviewed for this article, adding that the hospital is now working toward becoming LEED certified. "That decision was made from the conference."

Fischer considers himself green savvy. He majored in ecology in the early 1970s. "This (new green) movement to me has revived itself, picking up where we left off in the '70s," he says. "I've always been a part of that. It has been revived by realizing that the world is getting warmer and energy costs are increasing. Healthcare is always looking at how it can continue to keep expenses in line so it can put dollars to patient care, and sustainability efforts can help."



Parrish Medical Center's new outpatient facility used a variety of recycled material for its floors, walls, ceilings, etc.

Photos courtesy of Parrish Medical Center



- Purchasing pillows made with 100 percent recycled plastic. More than 100,000 pillows annually are purchased.
- Using coreless toilet paper in guest rooms. By the end of 2009, 500 hotels will offer coreless toilet paper. This is estimated to save roughly 120 trees, 3 million gallons of water used in the manufacturing process and 21 tons of packaging waste annually.
- Using oxo-biodegradable plastic laundry bags that disintegrate in two to five years.
- Donating food waste to pig farms.

Marriott also wants to reduce its water and energy consumption. It expects to lower water use 25 percent by 2017, using methods such as low-flow faucets and showerheads. Also, Marriott plans to incorporate solar technology at a handful of its hotels.

Another green program initiated throughout all of Marriott's hotels is Green Council, which is a group of volunteers in each department who want to take the Spirit to Preserve initiative even further by brainstorming ways to become even more environmentally sustainable.

A challenge, however, with green initiatives is funding them, as some programs are cost prohibitive, said Wright.

Another challenge is sustaining these kinds of programs, "considering the majority of our energy and water usage is by people who don't work for Marriott but are our customers," she said. "But sustainability goals can be met if they are realistic and employees' input is sought from the beginning."

Financial Sector

With many facilities that use a great deal of energy—and require ample resources to maintain—financial institutions are another good source for healthcare executives to tap into for sustainability ideas, said presenter Boschidar Ganev, environmental resources manager for JPMorgan Chase, New York.

Ganev's responsibilities entail quantifying and reporting the company's direct impact on the environment, coordinating projects to shrink the firm's environmental footprint and working on employee and business environmental engagement.

JPMorgan Chase created a blueprint of its environmental impact in the areas of energy use and greenhouse gas (GHG) emissions, paper, carbon offsets for air travel and waste management and recycling. Ganev said the blueprint is general enough that it can be applied to other industries, including healthcare. To get the most out of the blueprint, healthcare leaders should identify one or two elements to focus on the most, he said. JPMorgan, for example, spends the majority of its

time and money reducing energy and GHG emissions and paper usage.

Energy Consumption and Greenhouse Gas Emissions

JPMorgan Chase's No. 1 direct environmental impact concern is the amount of energy it uses and its greenhouse gas emissions. These areas also are a major concern for many hospitals and healthcare systems. To understand and manage the amount of energy consumed and the GHG associated with its 5,000 facilities—including some 14,000 ATMs—JPMorgan Chase established a greenhouse gas inventory. What it discovered was 90 percent of its GHG emissions were the result of electricity usage, with its data centers as a significant contributor.

Upon understanding its energy use and GHG emissions, JPMorgan began an energy reduction initiative in 2007 at key facilities. One of the largest projects is the renovation of its 50-story world headquarters in New York. Work at the 1950s-era skyscraper will be done 10 floors at a time.

"The interesting thing about this renovation is—as opposed to a new building where you can design from scratch—it's like changing a tire on a moving car," said Ganev. "But it is being undertaken with minimal disruptions to employees and customers."

Renovating within an existing building means JPMorgan has to stay within the confines of its existing building, which



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Energy efficiency in general office spaces includes efficient lighting, increased flow of natural light and motion sensor-controlled lights. In addition, heating and cooling, energy efficiency, plumbing and plumbing fixtures, wiring and safety features throughout the 1.3 million square foot building will be incorporated. Building materials and office furnishings meet improved air quality standards. Sustainable materials such as recycled content sheetrock and other materials and reclaimed and FSC-

certified wood are used for the walls and furniture of the new offices.

With these changes and others, the firm hopes to reduce its energy consumption by about 20 to 30 percent and ultimately save on energy bills. In addition, Ganev says JPMorgan expects the building to use 50 percent less water, aided in part by a rain water-collection system.

Paper Usage

JPMorgan's No. 2 environmental concern is the amount of paper it uses. This also is an area where healthcare organizations can look to reduce their environmental impact, said Ganev. JPMorgan's paper use is significant, and it has taken several steps to reduce it. JPMorgan tracks and measures its

paper consumption and allocates paper use by the organization's six lines of business, which operate independently and have different volumes of paper use. This approach provides accountability and helps streamline how the organization overall is able to measure paper use.

One of the most compelling paper-reduction areas to consider is with the customer, said Ganev.

JPMorgan, for example, provides customers with the choice to conduct paperless transactions. "This reduces our carbon footprint because it does away with paper account statements, which not only eliminates the paper, but also postage and the associated fuel consumption used to deliver the statements."

Fund for Innovation in Healthcare Leadership

"Healthcare Going 'Green': The Business of Environmental Sustainability" was funded in part by the American College of Healthcare Executives' (ACHE) philanthropic initiative, the Fund for Innovation in Healthcare Leadership.

It was the Fund's second educational program in 2008. In November a program on ethics, titled "Rising to the Ethical Challenges of Healthcare Leadership," was held. (Please see page 54 for a write-up on the ethics program.)

The Fund was established in 2006 to bring innovation to the forefront of healthcare leadership. In its commitment to developing future leaders, the Fund provided scholarships for affiliates to attend ACHE's multisession Senior Executive and Executive programs.

In 2008, almost 400 generous donors contributed more than \$300,000 in cash and pledges. This support enabled the Fund to strengthen the field of healthcare leadership by providing innovative opportunities on important trends and issues.

For information on the Fund, including ways to contribute, please visit ache.org/innovation, or contact Laura Wilkinson, assistant director, Development, at (312) 424-9305.

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In addition, customers can electronically deposit paper checks at ATMs without filling out a deposit packet. ATM technology scans the check and amount and enters it into the account.

says Robin Guenther, principal architect with Perkins & Will, Orlando, Fla., who is a national leader in the conversation linking public health, regenerative design and sustainability and was interviewed for this article.

buildings—buildings that heal or repair some of the damage that has been done,” she says.

Presenting at the Orlando session, R.E. LeMon, PhD, vice chancellor, Board of Governors, State University System of Florida, said healthcare organizations should look for ways to collaborate with others—higher-learning institutions in particular—because government funding for sustainability programs may be easier to obtain.

“Our medical schools and research endeavors are eager to collaborate with hospitals and other entities,” said LeMon. “Public and private organizations coming together is a winning combination because when you go to the federal government it is a stronger case for obtaining grant funding. And the State University System of Florida (which consists of 11 universities and colleges and 3,600 facilities on 31,000 acres with 300,000 students) has had luck with that.”

Another approach that the education field can use to ensure sustainability is to adopt an accountability paradigm that bases state funding on school performance, said LeMon.

“In that way we can show we are more productive, efficient and a better bargain for the state,” he said. “By doing this are we able to become sustainable.”

John M. Buell is a writer with Healthcare Executive.

“As the broader green building movement begins to move from buildings that ‘do less harm’ to ‘living buildings’ that ‘do no harm’—carbon-neutral, toxic-free, zero-waste and water-balanced—the healthcare industry finds itself increasingly drawn into the dialogue through its mission.”

—Robin Guenther, principal architect, Perkins & Will

Beyond reducing paper consumption with its customers, JPMorgan is consolidating its printers and using machines that have double-sided printing set up by default.

“These are real cost-saving measures,” said Ganey.

Education and Hospitals

There are surprising similarities between healthcare’s sustainability issues and those of education institutions. In developing LEED (Leadership in Energy and Environmental Design) guidelines for healthcare that apply to acute-care settings, the U.S. Environmental Protection Agency’s development committee found parallels between hospitals and school buildings. Similarities were found in how each approached indoor air quality issues, acoustics and “healthier materials” in the pursuit of building an environment that supports human health,

Likewise, strategies that apply to university campus planning have direct relevance to acute-care hospitals. The unique needs of acute-care hospital buildings—24/7 operation, a high level of regulatory oversight, long-life buildings with emergency and redundant systems—make them the second most energy intensive building type after food service, according to the Department of Energy Commercial Buildings Energy Consumption Survey data.

“As the broader green building movement begins to move from buildings that ‘do less harm’ to ‘living buildings’ that ‘do no harm’—carbon-neutral, toxic-free, zero-waste and water-balanced—the healthcare industry finds itself increasingly drawn into the dialogue through its mission,” says Guenther.

“On the horizon the green building movement is defining regenerative

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Gaining Efficiencies Through Shared Savings

Making Systemwide Investments in Energy and Operational Efficiency While Preserving Capital

“Shared Savings allowed us to invest in cost-saving, energy-efficient equipment without significantly impacting our debt capacity, which we are saving for higher priority investments.”

Robert Shapiro

Chief Financial Officer

North Shore–Long Island (N.Y.) Jewish Health System

An innovative financing program that allows hospitals to get needed infrastructure improvements without capital investment or debt obligation is gaining interest. Called “Shared Savings,” it is an arrangement that Johnson Controls, Inc., Milwaukee, offers to select organizations that helps them improve energy and operational efficiencies of their facilities in a highly affordable manner.

Johnson Controls began offering Shared Savings three years ago. By using Shared Savings, hospitals and health systems can address deferred infrastructure needs with modern equipment that is energy efficient and is environmentally friendly without having to use their own capital or take out a loan. A third party owns the related energy-efficient assets, while providing the beneficial use to the hospital and recovering its costs via a share of the measured and verified energy savings. This is a superior alternative to continued deferral of investment in infrastructure renewal, says Bob Mikulec, national business development director for healthcare at Johnson Controls.

“At the end of the day the hospital gets a no-lose proposition and actual use of the assets and saves some money through energy-efficient equipment,” he says.

The Shared Savings process begins when Johnson Controls Healthcare consultants evaluate and identify needed infrastructure improvements and present to hospital executives the projected return on investment. After the customer selects the project(s), payment options are discussed. The Shared Savings method is becoming a popular choice because it solves the two-budget (capital and operations) problem many organizations face by allowing the customer to pay for the project using funds from just one budget—operations.

“The facility improvements are paid for from the same operating budget that the savings come from,” says Mikulec. “It’s one bucket, and the customer always gains.”

In addition to developing the project, Johnson Controls identifies the facility improvement measures and related savings, installs the infrastructure/equipment and guarantees the pricing of the physical energy-unit savings over time.

“Shared Savings provides an affordable way to renew infrastructure by converting future waste into savings,” says Mikulec. “In essence, money you would have paid primarily to utilities in the future is redirected to provide modern infrastructure today.”

Putting Shared Savings to Work

A long-time Johnson Controls customer, North Shore–Long Island (N.Y.) Jewish Health System (LIJ), was an early adopter of Shared Savings. North Shore–LIJ consists of 14 hospitals, 17 long-term-care facilities and a handful of other facilities and is the third largest nonprofit, secular healthcare system in the nation. As with many nonprofit health systems, capital is always a concern as more facility improvement projects exist than there is money available to fund them.

In North Shore–LIJ's case, it had identified a number of large infrastructure renewal projects but had delayed many of them. When Johnson Controls approached North Shore–LIJ with a unique Shared Savings financing offer for one of its overdue projects—a new, \$8.8 million chiller system at North Shore University Hospital in Manhasset, N.Y.—North Shore–LIJ found Johnson Controls' proposal appealing in two ways.

"This is one of the first times that someone came to North Shore with a turnkey solution to allow us to invest in energy-saving equipment in which the financing is paid for over time from the savings engendered by the equipment," says Robert Pine, vice president, Treasury Operations, North Shore–LIJ.

A second attractive aspect of the Shared Savings arrangement was the chiller system being financed as an off-balance sheet transaction that used less of North Shore–LIJ's debt capacity than if it financed the project with a traditional loan, says Pine.

"Johnson Controls (in conjunction with a third party) came up with a plan that allowed us to finance the acquisition and installation of this turnkey project," says Pine. "North Shore and Johnson Controls will monitor the savings in the quantity of energy expended from a baseline,

and Johnson Controls guarantees to us that, based on a constant price of energy, we will generate sufficient savings from the equipment to pay for the debt service on the transaction."

The energy-efficient chiller system, which replaces a near 40-year-old cooling plant, consists of new cooling towers that require less water in the cooling process. "These improvements will help make North Shore–LIJ more sustainable by reducing its greenhouse gas emissions and water usage," says Steve Terrano, healthcare account executive at Johnson Controls.

Pine advises hospitals considering financing projects via Shared Savings to do their due diligence in two key areas: Obtain competitive bids of the equipment/infrastructure to "give you some control of the cost of the equipment," and hire independent consultants to review the overall engineering of the proposal to confirm Johnson Controls' analysis of cost savings.

"You really do need a skilled facility staff in order to ensure the savings are really there," he says.

Installation of the chiller system will be completed by the fall, and a Johnson Controls representative will be permanently available to help monitor the use of the equipment to ensure North Shore–LIJ engineers are using it properly to attain the maximum savings.

"If there are savings above the debt service, North Shore–LIJ can share in that with Johnson Controls," says Pine. "After 10 years, North Shore–LIJ gets 100 percent of the savings."

For more information, please contact Mark Reinbold, healthcare national accounts manager, Building Efficiency, Johnson Controls, Inc., at (314) 812-4688 or mark.r.reinbold@jci.com.

Rethinking Community Benefit Reporting

A Strategic View to a Stronger Commitment

By Susan Birk

New federal requirements for how nonprofit organizations report community benefit activities and charity care provide an opportunity for hospitals to rethink, redirect and reorganize their work in an area that is critical to their mission.

For community benefit activities that occur in their 2009 fiscal year, tax-exempt organizations are mandated to begin reporting them in 2010. The new reporting requirements of Form 990 for hospitals give nonprofit health systems and independent hospitals occasion to take stock of what they have accomplished and to identify ways they might more effectively serve the large and growing populations who need them.

“Given the increasing pressure on nonprofit healthcare organizations to demonstrate how their community benefit activities justify tax-exempt status, it seems clear that serious, ongoing dialogue by governing

boards about community benefit issues is becoming a necessary and important governance practice,” writes Lawrence Prybil, PhD, FACHE, professor of health management and policy, College of Public Health, University of Iowa, and his co-authors in *Governance in Non-Profit Community Health Systems: An Initial Report on CEO Perspectives* (2008). The report describes emerging benchmarks for effective governance, including those with respect to community benefit (see sidebar on page 38).

Healthcare Executive spoke with key community benefit thinkers, organizers and innovators who provided a framework for organizations to do some internal community benefit “soul searching” of their own—the kind of honest self-assessment that can lead to well-targeted services, measurable results, effective oversight of community benefit initiatives and improvements in public health.



“Community benefit reporting is an opportunity to ensure that a commitment to community benefit work is reflected throughout the organization and is integrated into the work and priorities of key functions such as strategic planning, budgeting and communications,” says Julie Trocchio, senior director of community benefit and continuing care ministries for The Catholic Health Association of the United States, Washington, D.C.

Planning Community Health Services

With that in mind, Trocchio encourages healthcare leaders to think of the reporting process as a catalyst for reflection (Are we adequately staffed with sufficient resources and board involvement? Are we making an impact in the community?) and as a time to reaffirm a commitment to community benefit initiatives based on prevention.

As most organizations already well know, community benefit should be more than an isolated function staffed by a part-time employee who makes a report once a year, Trocchio says; it is the provision of carefully planned community health services that address unmet needs and are driven by an organizational commitment to do more

than reactively deliver emergency room or inpatient charity care.

Trocchio suggests that nonprofit healthcare leaders ask themselves when decisions are made: Are our programs responding to community need? Are they community health-oriented? Are we working with community partners? Are we making an impact? “It would be a mistake to think of community benefit reporting only as numbers, and it would be a mistake to think of community benefit only in terms of charity care,” she says. “The role of nonprofit providers goes beyond taking care of people who come to our facilities who are sick and injured. It also should be keeping people well and making sure that everyone in the community has access to needed health services, which is a very different way of looking at things.”

Kevin Barnett, DrPH, a senior investigator at the Public Health Institute, Oakland, Calif., says this “different way of looking at things” means that “we must become good stewards of those who are most in need in our community.” Taking on the role of steward requires an organizationwide system of thinking, acting and financing that is firmly aligned with prevention, he says.



Rethinking Community Benefit Reporting

A Strategic View to a Stronger Commitment

In Barnett's view, this means sharpening the focus on keeping people healthy. He says the need for organizations to make this shift is becoming increasingly urgent as more baby boomers enter the chronic disease stages of their lives and demands on healthcare systems continue to rise.

"Community benefit should be more than an isolated function staffed by a part-time employee who makes a report once a year. It is the provision of carefully planned community health services that address unmet needs and are driven by an organizational commitment to do more than reactively deliver emergency room or inpatient charity care."

—Julie Trocchio, The Catholic Health Association of the United States

The view of community benefit as synonymous with the provision of charity care, a view held by many policy makers, puts undue pressure on nonprofit organizations to focus on the delivery of ER care and inpatient medical services for the growing number of uninsured, Barnett asserts.

"A significant proportion of nonprofit hospital revenue for charity care and other community benefits depends on cross-subsidization from commercially insured patients; at the same time, investor-owned health plans that cover these commercially insured patients make their money by paying less and less

for procedures," he says. "The net result is less surplus revenue available to care for uninsured and underinsured populations."

The glaring reality that "the majority of charity care hospitals provide is for eminently preventable illness" factors heavily into this equation, says Barnett. Nonprofit organizations are all too familiar with the following scenarios: the child who comes to the ER because he doesn't have a pediatrician; the diabetic who enters the hospital for digit or leg removal because she does not have a primary care physician; the individual who is repeatedly readmitted to the hospital because he goes back into the community without an effective community support system to care for him and reduce the chances of readmission.

"Doesn't it make more sense for us to ask how hospitals can work together with local agencies and community groups to address the underlying causes of these illnesses?" Barnett asks.

Many of the nonprofit healthcare providers that have taken these steps have begun to see the wisdom of this strategy, he says. The visionary organizations that have embraced a preventive approach to community benefit and shifted from a focus on fee-for-service to effective population health management "have made more money by allocating resources to keeping

people healthier and out of the hospital," he says.

Getting the Board Involved

Barnett's extensive work with a cohort of 70 hospitals throughout Arizona, California, Nevada and Texas on the 18-month demonstration project known as Advancing the State of the Art in Community Benefit delved into a variety of programmatic and institutional issues to enable nonprofit organizations to begin proactively delivering care to the community.

A major outgrowth of the project in the institutional domain was a set of uniform standards around governance designed to help organizations improve the effectiveness of their community benefit initiatives.

One of these core standards is the formation of a board-level community benefit oversight committee. According to the standard, the committee should be composed of one or two members of the board of trustees, the CEO and one or two other members of the senior leadership team, typically the CFO, the chief nursing officer or the chief medical officer.

The committee also should include community stakeholders chosen specifically for their ability to bring needed skills to the table.

The inclusion of these stakeholders, says Barnett, moves the organization

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Rethinking Community Benefit Reporting

A Strategic View to a Stronger Commitment

from a representational model that loads community benefit oversight responsibility fully on the board of trustees to one based on the skill sets needed to provide effective oversight and help the organization make sound decisions concerning the optimal use of its charitable resources.

“When your CEO truly embraces these concepts, magic happens. If the CEO doesn’t get it, then the board won’t get it, and the hospital never will do it.”

—Dawn Marie Kotsonis,
Presbyterian Intercommunity
Hospital

Often, this model translates into a committee composed of individuals with expertise in epidemiology, utilization data analysis, primary prevention and inter-sectoral collaboration, says Barnett. An asthma prevention program, for example, is more likely to yield measurable results if it is supported by individuals with experience in working with the local housing authority to address problems related to cockroaches, dust mites and 30-year-old carpeting, major sources of high asthma acuity rates within low-income communities, he says.

In addition to standards for committee formation, the demonstration

project also yielded standards regarding criteria for committee inclusion based on needed skills, a process for recruiting and screening committee members and clarification of committee members’ roles and responsibilities.

The standards include an orientation process to help committee members fully understand their roles and functions, Barnett says. “The process begins to shift the power for decision making from the CEO, who is being pulled in five directions, to a group that focuses the organization on doing the things that it does well and where (it) will do the most good.”

Real-Life Example

Presbyterian Intercommunity Hospital (PIH), Whittier, Calif., took part in the Advancing the State of the Art in Community Benefit demonstration project and has implemented or is planning to implement all of its community benefit policies and procedures. PIH’s involvement in the

demonstration “revolutionized how we think about community benefit,” says James R. West, president and CEO. By way of example, he cites the hospital’s mobile health clinic for providing screenings for older adults. “According to the old definition, we might have considered that community benefit; according to the new definition, it’s marketing because these people are insured.”

West says the hospital also realized “that we’re not here to do charity work for uninsured patients in the ER. We’re here to care for the overall well-being and health status of the community.”


As a result, the hospital has begun to rethink its approach to patients who receive uncompensated care in terms of potential opportunities to serve the community—service that begins with learning more about who these people are and then managing individuals on a case-by-case basis. “If you take the dollars that you’re writing off, probably for

Related ACHE Resources

- *Achieving Success Through Community Leadership* (Health Administration Press, 2001)
- “Community Benefit Reporting, IRS Form 990 and the Mission of Nonprofit Healthcare” (seminar)
- “Ramping Up Community Benefit: What You Need to Know to Comply with New and Future IRS Regulations” (webinar)

For more information, visit ache.org.





a fraction of that amount you could provide care that would keep these people out of the hospital,” says West. “If you can spend \$2 million and save \$6 million, wouldn’t you spend \$2 million?”

The community benefit transformation at PIH began with the creation of a community benefit oversight committee, according to West. In addition to board members and senior staff, the committee includes representatives from the local department of health services and other community agencies, including the director of the local homeless shelter. “We realized that doing everything ourselves was never going to fulfill community needs and that bringing along the appropriate people at the appropriate time made a lot more sense,” he says.

“When you bring in people from the community, they have to know that you’re providing value and that you will do what you say. The policies and procedures give community stakeholders the assurance of knowing that once a decision is made, it will be implemented.”

—James R. West, Presbyterian
Intercommunity Hospital

After forming the committee, the hospital implemented policies and procedures to establish a system for vetting, approving and monitoring projects. “This way, when we launch a community benefit project, we know that it meets defensible goals,” West says.

The CEO’s involvement and commitment at PIH are absolutely central to this process, says Dawn Marie Kotsonis, community benefit manager at PIH.

“When your CEO truly embraces these concepts, magic happens,” she says. “If the CEO doesn’t get it, then the board won’t get it, and the hospital never will do it.”

Kotsonis notes that the hospital has adopted an approach to community benefit initiatives as business initiatives, and this strategy has served the organization well. “We take the data from our community needs assessments and apply the same good business principles to the initiatives that we would apply to any other successfully run business,” she says. “Rather than just responding emotionally and dreaming up a bunch of programs, we plan strategically to make sure we harness the appropriate community assets, involve the people who are going to be the consumers of that initiative to make sure we’re on target and document the outcomes to demonstrate the improvements we’ve made.”

The hospital also strategically evaluates community needs in terms of their probability for success and for their potential value to the community, Kotsonis says. A burn-care initiative may have inherent value, for example, but the project’s viability is limited if the community lacks a burn service.

The development of a community benefit oversight committee, policies and procedures has built credibility for the hospital’s initiatives, says West. “When you bring in people from the community, they have to know that you’re providing value and that you will do what you say. The policies and procedures give community stakeholders the assurance of knowing that once a decision is made, it will be implemented. Once the committee has a proposal that meets requirements and decides to go forward with it, and the board agrees, then we implement it. The program is not going to fall into the hands of people who might decide they don’t want to move ahead.”

Fortunately, a growing number of other nonprofit healthcare organizations and leaders have devoted themselves to making similar changes, says Barnett. He sees, for example, a positive movement by many organizations toward the creation of a stronger firewall between what constitutes community benefit and marketing. “Most healthcare leaders are aware of the effective approaches and are working to motivate their organizations,” he says. “I think we are moving in the right direction.”

Susan Birk is a freelance writer based in Wheaton, Ill.

Aiming High: Community Benefit Benchmarks

In *Governance in Non-Profit Community Health Systems: An Initial Report on CEO Perspectives* (2008), Lawrence Prybil, PhD, FACHE, professor of health management and policy, College of Public Health, University of Iowa, and his colleagues report the results of a survey of 123 community health system CEOs to identify the emerging benchmarks of good governance, including effective governance with respect to community benefit activities.

According to the report, these community benefit benchmarks include:

- The development of a systemwide policy regarding community benefit roles and obligations.
- Active collaboration with other community organizations in assessing the needs of the community in an ongoing fashion.
- Creation of a formal community benefit plan stating the system's objectives in clear, measurable terms: "It can be a freestanding plan or part of an overall strategic plan, but it should spell out the organization's priorities in community benefit because no hospital or system can be all things to all people; there have to be focal points and limits," Prybil says.
- The establishment of formal reporting and monitoring mechanisms. "Is the organization accomplishing what we hope it will and what we've said it should?" says Prybil. "These activities should be done regularly, the reports should be formal and the board should discuss how it is doing in relation to its responsibilities and take action if it is not meeting them."
- Thorough reporting to the communities served on a regular basis, preferably annually.

Although benchmarks are surfacing, a substantial portion of hospitals have not yet met them, according to the report. In general, the gaps appear to be bigger for independent health systems than for health systems affiliated with larger parent organizations.

For example, 55 percent of community health systems affiliated with a parent organization have formal community benefit plans that have been adopted by their boards as compared to only 25 percent of the independent systems, according to the report.

Although there is room for improvement across the board, Prybil says, "My hunch is that the community health systems that are part of larger organizations receive some direction and guidance from the parent organization. It's very likely that these parent organizations are advising their local community health systems about the importance of being proactive, whereas independent systems don't have another body providing oversight."

Prybil emphasizes that "all of the benchmarks we looked at are very attainable and, in fact, are being attained by many systems. We hope that boards and their CEOs ask, 'How can we do this?' There is no reason why all systems should not be able to set targets, identify their priorities and meet the benchmarks."

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CONGRESS WRAP-UP

More than 4,000 current and future healthcare executives recently gathered in Chicago to participate in various seminars, lectures, ceremonies and networking opportunities offered at ACHE's 52nd Congress on Healthcare Leadership. At the meeting, attendees discussed and learned about new trends in the evolving healthcare management field. Following are highlights of the event.

EVANS LOOKS TO THE FUTURE IN THE MIDST OF CHALLENGES



Immediate Past Chairman MG David A. Rubenstein, FACHE (left), presents 2009–2010 Chairman Charles R. Evans, FACHE, with his Chairman certificate.

“ACHE has now completed its 75th year. Two-thousand and eight was a time to reflect on how we’ve grown and all that we have achieved. But this is 2009. Today, I want to talk about our future. I want to look forward to our centennial—to our next 25 years of service and leadership,” said ACHE Chairman Charles

R. Evans, FACHE, to attendees of Monday’s Opening Session.

Evans believes healthcare executives should think about the future. “We face unprecedented challenges on a number of levels,” he said. “I’m convinced that the people in this country and indeed around the world are counting on us to find solutions to the most pressing healthcare challenges.”

Evans elaborated more on those challenges. “First, I don’t have to tell you that we’re confronted by a number of national challenges that are unprecedented in scope, such as the daunting task of restructuring the payment system, managing increasing costs, dramatically improving safety and quality, adapting to a changing workforce and meeting the growing expectations of our constituents.

“Second, I think we must embrace a global view in addressing healthcare issues,” he continued. “It is too late to say no to globalization. We live in a world where our destinies are shared.

“The third challenge we face is personal,” he said. “It has to do with the

day-to-day realities of our work—realities that put us at risk of being disconnected from our high calling. The consequence is that we tend to lose our way, we fail to see the incredible opportunities ahead, and we are less effective as leaders during this crucial time.”

In order to help solve these challenges, Evans described three actions executives should take. “First, we need to get our balance,” he said. “Second, we need to recommit to our calling. And third, we need to engage with creative energy.”

Evans thinks that the next 25 years in healthcare hold great promise. “I believe that we will see a movement to professionalize healthcare management around the world and particularly in developing countries,” he said. “There is a global hunger for the value that professional healthcare management brings to delivery systems.

“The pace of development in the clinical arena over the next 25 years will require our profession to continue to advance as effective leaders

of change and world-class managers of resources,” he continued. “Perhaps most importantly, we will be called upon to direct the process of confronting the ethical and social dilemmas that will result from these incredible clinical advances.”

Evans said current healthcare executives will have opportunities to leave positive legacies to future leaders. “There is no doubt that if we maintain our balance, recommit to our calling, and engage in our work with vigor and creativity, we can make a difference in our institutions, in our communities and in our world,” he said. “We have the resources and the know-how to manage the challenges we face and to lead the way into an incredible future.”

Evans was officially installed Saturday, March 21, during ACHE’s Council of Regents Meeting. Highlights of his career and service with ACHE can be found in the March/April 2009 *Healthcare Executive* on ache.org.

NEAMAN WINS GOLD MEDAL AWARD



Mark R. Neaman, FACHE (left), receives his award from Immediate Past Chairman MG David A. Rubenstein, FACHE.

Mark R. Neaman, FACHE, president/CEO, NorthShore University

HealthSystem, Evanston, Ill., is the recipient of this year’s Gold Medal Award. Neaman received his award during the Arthur C. Bachmeyer Memorial Address and Luncheon on Monday, March 23.

The Gold Medal Award is ACHE’s highest honor given to outstanding leaders who, through a career of service, have made significant contributions to the healthcare profession and field. The purpose of this award is to identify ACHE Fellows who best exemplify leadership at the organizational, local, state/provincial and national levels. The Gold Medal Award recognizes those individuals who go beyond the confines of their own organizations to continually contribute to the improvement of healthcare services and community health.

Neaman began his career in healthcare in 1974 as an administrative assistant at Evanston (Ill.) Hospital. Two years later he was promoted to assistant to the vice president, patient care services, a role he served in until 1978.

For the next six years, Neaman moved into a series of increasingly responsible vice president positions within Evanston Hospital before becoming president in 1984, a position he held until 1988. Also in 1984, Neaman was named executive vice president/COO of Evanston Northwestern Healthcare. He served in that role until 1992 when he was

chosen, at the age of 41, as president and CEO, the position he has held for 17 years.

Under Neaman’s leadership, in 2003 Evanston Northwestern Healthcare (ENH) became one of the first in the country to successfully launch a systemwide, state-of-the-art electronic medical record (EMR) system with demonstrable benefits in quality, safety, efficiency and service to patients. A year later the health system won the Healthcare Information and Management Systems Society (HIMSS) Davies Award and was recognized by Leapfrog. In 2005 Neaman was named IT CEO of the Year by HIMSS.

In 2005 the organization was one of the first healthcare providers in the United States to create a comprehensive, universal MRSA surveillance program, swabbing patients for the virus. The health system has seen a 70 percent reduction in MRSA infection rates in less than two years. In September 2008, ENH changed its name to NorthShore University HealthSystem.

Neaman’s effective healthcare leadership abilities reach beyond the corridors of NorthShore University HealthSystem as evident during his time as chairman of the Healthcare Leadership Council, a position he held from 2005 to 2006. As chairman, he spearheaded an energetic, visionary agenda aimed at improving the quality of healthcare for all

CONGRESS WRAP-UP

Americans. The initiative linked uninsured Americans with both public and private healthcare coverage resources. Neaman also led a campaign to employ community organizers throughout the country and train thousands of volunteers to explain a new Medicare prescription drug benefit program to senior citizens.

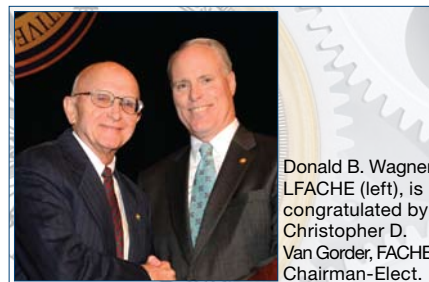
Neaman also has been a leader for the Illinois healthcare community. From 2004 to 2005 he played a key role on the Illinois Hospital Association's Medical Liability Reform Steering Committee, which helped push for legislation to reverse a crisis that was driving physicians out of the state and jeopardizing access to healthcare due to skyrocketing costs of liability insurance premiums. Previously, he served as a member of the association's board of trustees from 1989 to 1994.

Neaman is a member of a number of professional organizations, including the American Hospital Association, Association of American Medical Colleges, Healthcare Leadership Council, International Hospital Federation, Health Insights Foundation and the Institute of Medicine of Chicago. He also has earned numerous educational and professional awards and honors. In 1980, he was granted the Distinguished Fellowship from the International Hospital Federation and in 1988 was named Young Healthcare Executive of the Year by ACHE,

The Ohio State University Distinguished Alumnus of the Year and an On the Rise executive by *Fortune* magazine. Neaman earned both a master of science/business and healthcare administration degree and a bachelor of science degree from The Ohio State University.

Board certified in healthcare management as an ACHE Fellow, Neaman has served on numerous committees, as Regent from 1990 to 1994, Governor from 1997 to 2001 and Chairman-Elect, Chairman and Immediate Past Chairman from 2001 to 2004. During his tenure as chairman, he was instrumental in the design and implementation of the organization's new chapter system, strengthening its relationships with loosely affiliated groups and bringing additional educational and career development opportunities to members at the local level. Under Neaman's leadership an inaugural group of 60 ACHE chapters was chartered in March 2004.

WAGNER RECEIVES LIFETIME SERVICE AWARD

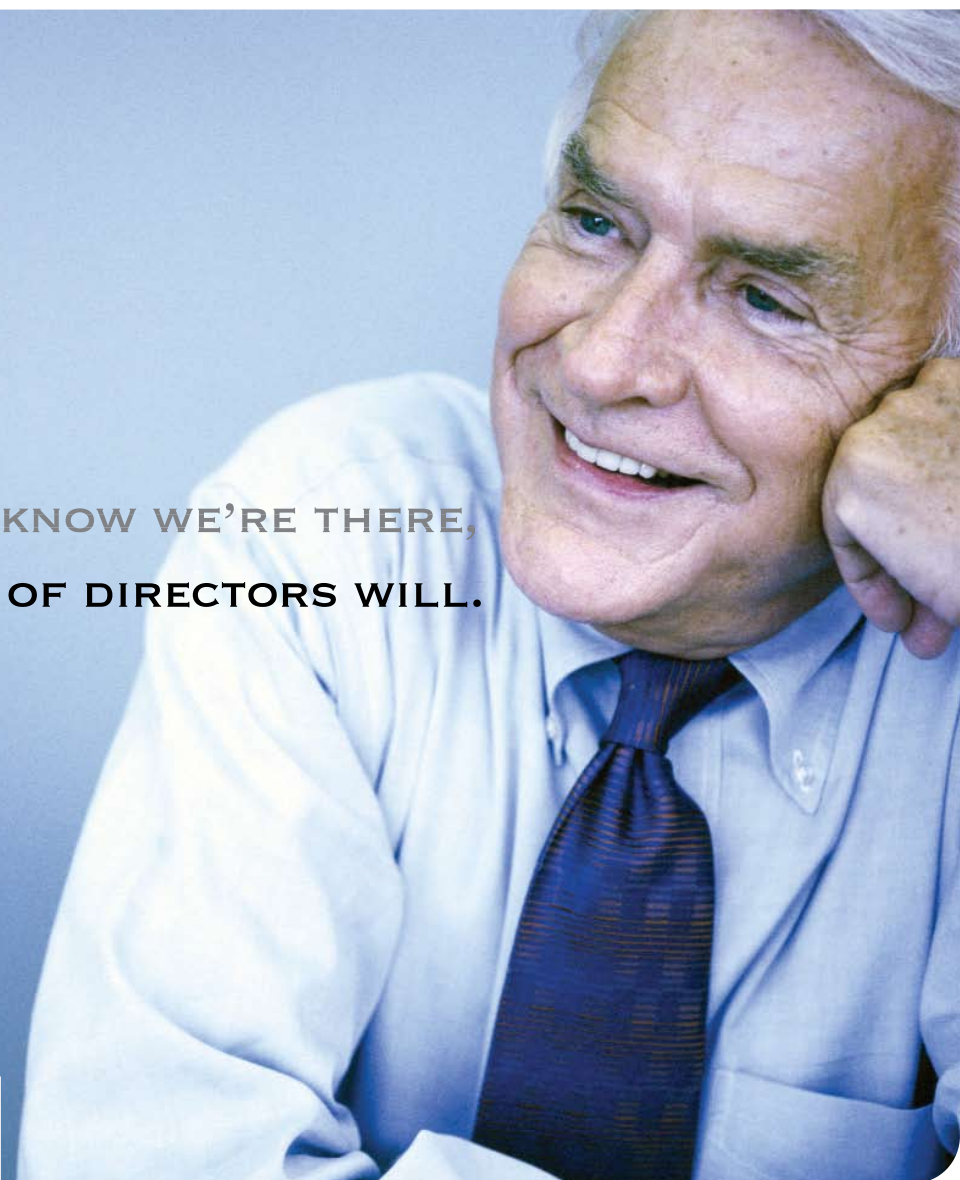


Donald B. Wagner, LFACHE, was named this year's winner of ACHE's Lifetime Service Award. Wagner

received the award during the Malcolm T. MacEachern Memorial Lecture and Luncheon on Tuesday, March 24. The Lifetime Service Award was established in 2000 to recognize healthcare executives who have made substantial contributions to ACHE during their careers. It is awarded to a Life Fellow or Retired Fellow who has made significant contributions to ACHE through elected office, has served on ACHE committees or task forces and has participated in ACHE activities or affiliated groups.

Wagner began his healthcare career in 1952 in the United States Air Force as Chief of Physical Therapy at Randolph Air Force Base in Texas. On a recommendation from his superior, Wagner was encouraged to transition to healthcare management, and from 1955 to 1962 he held various Air Force medical posts. He also earned his graduate degree during this time frame.

Wagner was stationed at a number of U.S. Air Force headquarters operations. He served in Washington, D.C., from 1962 to 1966 in the Consultant's Division, Directorate of Professional Services Office of the Surgeon General. He was then transferred overseas to Headquarters, U.S. Air Force Europe in Wiesbaden, Germany, where he served until 1969 as Chief, Facilities and Financial Programs, Office of the Surgeon. He then returned to Texas, where he served until 1973 as Chief, Medical Corps Assignments and Utilization,



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Air Force Military Personnel Center, followed by a two-year assignment in the capacity of Deputy Commander, School of Health Care Sciences.

From 1975 to 1979 he was CEO and Administrator at Wilford Hall Medical Center at Lackland Air Force Base in Texas. From 1979 to 1982 he was Chief, Medical Service Corps, U.S. Air Force, and Director, Health Care Support Directorate, Office of the Surgeon General, U.S. Air Force.

During this period, Wagner was promoted to Brigadier General, the first time in the Air Force Medical Service Corps' 30-year history that a non-physician hospital administrator was promoted to that rank. With this promotion, Wagner was named the U.S. Air Force Deputy Surgeon General for Operations, and Commander, Air Force Medical Service Center, Headquarters, U.S. Air Force. Wagner retired from the U.S. Air Force in 1982.

During his time in the Air Force, Wagner played an instrumental role in the Air Force's decision to allow Medical Service Corps (MSC) officers to receive support for participating in professional society organizations such as ACHE. Previously only physicians and dentists within the Air Force were given this kind of support. Eventually, with Wagner's help, MSC officers were clearly identified by their status as an ACHE member.

Following his career in the Air Force, from 1982 to 1985 Wagner served as associate vice president for hospital operations and hospital administrator at the University of Texas System Cancer Center, M. D. Anderson Hospital and Tumor Institute in Houston, and from 1985 to 1991 as vice president and CEO of Memorial Southwest Hospital in Houston. He then went on to serve as an internal consultant at Memorial Hermann Healthcare System in Houston, where he remained until 2004. He is currently a healthcare consultant in his privately owned business.

Wagner has been a member of many professional organizations and continues to serve in leadership roles for a number of them. He is a member and past chairman of the board of trustees, Texas Institute for Health Policy Research, Texas Hospital Association, and member, Advisory Board, Graduate Programs in Healthcare Administration at Texas A&M University, Baylor University and Texas Women's University.

Wagner's honors and awards include Outstanding Alumnus, Baylor University-U.S. Army Graduate Program in Hospital Administration; *Who's Who in America*, Forty-Sixth Edition; Commitment to Excellence Award, United States Air Force Medical Service Corps; and the Ray E. Brown Award from the Association of Military Surgeons of the United States.

He received his master's degree in hospital administration from Baylor University in Waco, Texas, and his bachelors of science degree in physical therapy from the College of Physicians & Surgeons at Columbia University in New York, N.Y.

Board certified in healthcare management as an ACHE Fellow, Wagner received a Service Award in 2008 and a Regent's Award in 2004. He has served on many ACHE committees and currently is on the Management Series Editorial Board, serves on the Regents Advisory Council and sponsors the Excellence in Healthcare Leadership Award given annually at the Joint Federal Sector awards breakfast at the Congress on Healthcare Leadership.

UNGER WINS ACHE'S YOUNG HEALTHCARE EXECUTIVE OF THE YEAR AWARD



Kevin L. Unger, FACHE, was named winner of ACHE's 2009 Robert S. Hudgens Memorial Award for young healthcare executive of the year. Unger accepted the award at the Congress Opening Session on Monday, March 23.

Unger is the 41st winner of the Hudgens Award, which is given

annually to an exceptional healthcare executive who is under 40 years old and who is the chief executive officer or chief operating officer of a health services organization.

The Hudgens Award was established in 1969 by the Alumni/ae Association of the Department of Health Administration at Virginia Commonwealth University, Richmond, in tribute to its former course director and ACHE's first vice president, Robert S. Hudgens, FACHE.

Unger began his career in healthcare management in 1996 when he served a one-year administrative internship and then a one-year stint as an analyst in the business development division at University Hospital in Denver, Colo. Following a brief time in 1998 at the University of Colorado Health Sciences Center in Denver, Unger was hired in 1999 as a consultant for First Consulting Group, also in Denver. In 2001, he was selected to serve as vice president, planning and strategic development, at Poudre Valley Health System in Fort Collins, Colo. After two years, he was named vice president, operations and ambulatory services, at Poudre Valley Hospital, and in 2005 he was promoted to president and CEO, a position he holds today.

Unger's passion for excellence and his outstanding communication abilities, leadership qualities, motivational management style and compassionate, friendly personality place him in the top tier of young healthcare executives.

Poudre Valley Hospital's clinical outcomes have improved significantly under Unger's leadership. Patient satisfaction has improved with scores increasing to 80 percent by the end of 2008 from 72 percent in 2002.

Hospital-acquired infections have decreased by 8.5 percent, with the hospital experiencing no critical medication errors for more than 12 months.

Unger's enthusiastic style and vision are responsible for the hospital's progressive position. He was the leading advocate for the hospital entering the field of robotic-assisted surgery.

To provide ongoing education, training and assistance to others in the profession, Unger supports a one-year paid administrative residency for advanced degree students who work alongside him and other hospital senior leaders.

During Unger's tenure, Poudre Valley Hospital has received numerous awards and accolades. The most recent honor was the Malcolm Baldrige National Quality Award, given to Poudre Valley Hospital's parent organization, Poudre Valley Health System. Unger served as a national examiner for the National Malcolm Baldrige program for two years. Poudre Valley Hospital also has annually been named by Thomson Reuters Healthcare as one of America's 100 Top Hospitals for superior clinical outcomes, patient safety and operational performance. Other accolades include

HealthGrades Inc. awards for clinical excellence and patient safety from 2005 to 2008 and a Magnet Hospital for Nursing Excellence in 2000 and 2004. In 2007, Unger was a recipient of *Modern Healthcare* magazine's Up & Comers award.

Unger is affiliated with a number of professional organizations. He is a member of the Colorado Health and Hospital Association's healthcare reform task force, a board member of VHA's Mountain States and a member of the Healthcare Financial Management Association.

He received his master's in business administration and master's of science in health administration from the University of Colorado at Denver, and he earned his bachelor's degree in sociology from Colorado State University.

Board certified in healthcare management as an ACHE Fellow, Unger serves on ACHE's Programs, Products and Services Committee.

PUBLICATION AWARDS GIVEN AT CONGRESS

The following award winners were honored at various Hot Topic Sessions throughout Congress:



Hamilton Award

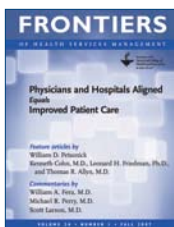
John J. Nance, JD, is the recipient of the 2009 James A. Hamilton book of the year award for *Why*

CONGRESS WRAP-UP

SUBMISSIONS WELCOME FOR 2010 CONGRESS

The Division of Education is inviting submissions for the 2010 Annual Congress on Healthcare Leadership. The RFP is on ache.org and will guide individuals through the submission process, including a list of suggested topics. See ache.org/education for deadline information. If you have questions, contact Maureen McLachlan, associate director, Division of Education, at mmclachlan@ache.org.

Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care, published by Second River Healthcare Press. The award was presented on March 24 at the Tuesday Hot Topic Session #1. The award is given annually to the author(s) of a management or healthcare book judged outstanding by ACHE's Book of the Year Committee. The James A. Hamilton Award is underwritten by the Alumni Association of the Graduate Program in Healthcare Administration of the University of Minnesota, Minneapolis, in honor of the late James A. Hamilton, FACHE, the program's founder and course director between 1946 and 1966 and ACHE's 1939–1940 Chairman.



Conley Award
Kenneth Cohn, MD, FACS,
Leonard H. Friedman, PhD,
and Thomas R.

Allyn, MD, FACP, were named the winners of the 2009 Dean Conley Award for their article "The Tectonic Plates Are Shifting: Cultural Change vs. Mural Dyslexia," published in the fall 2007 issue of *Frontiers of Health*

Services Management. The award was presented on March 25 at the Wednesday Hot Topic Session #1. Named for ACHE's executive director from 1942 to 1965, the Dean Conley Award is granted annually to recognize the contributions made to healthcare management literature and to encourage healthcare executives to write and publish articles. The article was selected by ACHE's Article of the Year Awards Committee.



Hayhow Award
Cheryl B. Jones, PhD, RN, FAAN,
Donna S. Havens, PhD, RN, FAAN,
and Pamela A.

Thompson, RN, FAAN, are the winners of the 2009 Edgar C. Hayhow Award for their article "Chief Nursing Officer Retention and Turnover: A Crisis Brewing? Results of a National Survey." The article appeared in the March/April 2008 issue of the *Journal of Healthcare Management*. The award was presented on March 25 at the Wednesday Hot Topic Session #2. ACHE grants the Hayhow Award annually to the author(s) of an article judged the best from among

those published in the *Journal of Healthcare Management*, ACHE's official journal. Named in honor of ACHE's 14th Chairman, the Edgar C. Hayhow Award recognizes outstanding contributions to healthcare management literature. The article was selected by ACHE's Article of the Year Awards Committee.

Chapter Management and Awards Program, Plus Regent's Awards

CT Association of Healthcare Executives received the Award for Chapter Excellence for meeting all three performance standards as part of ACHE's Chapter Management and Awards Program (MAP). The 2008 performance standards were:

- **Indexed attendee hours:** Chapters provided at least 5.40 hours of chapter event programming.
- **Net membership growth:** Chapters had a net membership growth of 8 percent.
- **Level of member satisfaction:** Chapters received 7.64 or higher on a 10-point scale in chapter member satisfaction.

Nine chapters won the Award of Chapter Distinction, which awards chapters that meet at least two of the three performance standards. Thirty-two chapters won the Award of Chapter Merit for meeting at least one of the three performance standards.



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James Y. Lee, FACHE, Regent for New York—Metropolitan New York, and executive vice president and COO, Lawrence Hospital Center, Bronxville, won the Regent's Award for Best Regent Newsletter in 2008. Lee's newsletter message promotes local events and activities to encourage affiliates to be more engaged with the chapter. He recognizes the hard work of chapter leaders and volunteers and the accomplishments of chapter members. Lee's casual, natural style makes reading the newsletter easy, engaging and fun.

Terrence F. Cahill, EdD, FACHE, Regent for New Jersey and

associate professor, Seton Hall University, South Orange, won the Regent's Award for Best Regent-Led Chapter Collaboration Project in 2008. He developed the project named "Advancing Healthcare Leadership: Many Roads to Success—A Dialogue With CEOs," which was a collaboration among the New Jersey Hospital Association, Seton Hall University and three ACHE chapters. The project was designed to create a dialogue between practicing CEOs and program attendees about what it takes for healthcare leaders to be successful in today's environment.

Rooney, Clemmons Win ACHE Richard J. Stull Student Essay Competition in Healthcare Management

Six winners accepted their awards for the ACHE Richard J. Stull Student Essay Competition in Healthcare Management on Wednesday, March 25, at the Leon I. Gintzig Lecture and Luncheon. The competition was developed to stimulate student writing about important issues and developments in healthcare management. It is open to active ACHE affiliates enrolled in either a graduate or an undergraduate U.S. or Canadian health administration program that is part of ACHE's Higher Education Network. The competition was named in honor of ACHE's fourth CEO, Richard J. Stull, FACHE, who served from 1965 to 1978.

The following first-place winners each received \$3,000 and a plaque, and their schools each received \$1,000. In addition, their essays will be published in the *Journal of Healthcare Management*, ACHE's official journal.

Keila M. Rooney, University of Central Florida, won first place in the graduate division for her essay, "Consumer-Driven Healthcare Marketing: Using the Web to Get Up Close and Personal."

Undergraduate **Allison L. Clemmons**, University of Alabama-Tuscaloosa, placed first with "Organ Transplantation: Markets or Altruism."

TOP PARTICIPANTS IN THE 2008 LEADER-TO-LEADER PROGRAM

At the Tuesday, March 24, Hot Topic Session #2, ACHE affiliates who recruited the greatest number of new Members and successfully encouraged the greatest number of new Fellows through the Leader-to-Leader Program were recognized. The top participants were honored in three recruitment categories:

- **Hospitals, Health Systems and Other Healthcare Settings Category:** Iona Canada, corporate manager of healthcare management of Trane in Antioch, Tenn.
- **Uniformed Services/Veterans Affairs Category:** Cathi Spivey-Paul, FACHE, director of the VA Northern Indiana Healthcare System in Fort Wayne.
- **Academic Category:** M. Nicholas Coppola, PhD, FACHE, program director and associate director of the Master of Science Clinical Practice Management program at Texas Tech University Health Sciences Center in Lubbock, Texas.

ACHE has launched the 2009 Leader-to-Leader Program. We invite you to take part by recruiting new Members or encouraging Members to advance to Fellow status. With your help, ACHE can continue to build relationships and strengthen our membership, one by one. Watch your mail and ache.org for details.

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CONGRESS WRAP-UP

The following second-place winners each received \$2,000 and a plaque: In the graduate division, **Ryan W. O'Donnell**, University of Michigan-Ann Arbor, placed second with his essay, "Co-Creating Value: A New Way to Achieve Patient-Centered Care." In the undergraduate division, **Kristina L. Griffin**, University of New Hampshire, won second place with "Conflicts of Interest for Healthcare Providers: Caveat Emptor."

The following third-place winners each received \$1,000 and a plaque: **Christina Stica**, Missouri State University, won third place in the graduate division with her essay, "Development of Cumulative Model Application for Healthcare: Attaining Excellence in Quality, Flexibility, Delivery and Cost." **Scott A. DiDonato**, James Madison University, placed third in the undergraduate division with "Evaluating the Adoption of Electronic Health Records: What Do Administrators Need to Know?"

New VA Fellows Recognized

ACHE wishes to acknowledge the new Fellows employed by the Department of Veterans Affairs who were inadvertently listed in the 2009 Convocation program booklet geographically rather than by their VA affiliation, which is customary. Below is the amended list.

Veterans Affairs

John C. Allen, FACHE,
Long Beach, California
Kenneth W. Allensworth, FACHE,
Wichita, Kansas

Patricia E. Arola, DDS, FACHE,
District of Columbia
Janna Belote, FACHE,
North Little Rock, Arkansas
Miyako K. Chambliss, FACHE,
Alexandria, Virginia
Joan M. Clifford, RN, FACHE,
Everett, Massachusetts
Angel L. Colon-Molero, MD,
FACHE, North Miami, Florida
Glenn A. Costie, FACHE,
Baltimore, Maryland
William E. Cox, FACHE,
Clarksburg, West Virginia
Walt C. Dannenberg, FACHE,
San Antonio, Texas
Bernard G. Deazley, FACHE,
Portland, Oregon
Ajay Dhawan, MD, FACHE,
Fort Myers, Florida
Maureen A. Dicker, FACHE,
Mesa, Arizona
Denise M. Harrison, RN, FACHE,
Lincoln, Nebraska
Roy L. Hawkins Jr., FACHE,
Orlando, Florida
Elizabeth S. Helsel, FACHE,
Vintondale, Pennsylvania
Jeffrey Hull, FACHE,
Fort Wayne, Indiana
Donna K. Jacobs, FACHE,
Lexington, Kentucky
Steve P. Kleinglass, FACHE,
Minneapolis, Minnesota
Patricia G. Lay, FACHE,
Ann Arbor, Michigan
Mary M. Levenson, FACHE,
Belleair Beach, Florida
Lavonne Liversage, FACHE,
Fargo, North Dakota
Katheryn P. Mansell, FACHE,
Chicago, Illinois

Frederick R. McLain Jr., FACHE,
Gaithersburg, Maryland
Frank M. Miles, FACHE,
Clarksburg, West Virginia
Marcia M. Mylan, PhD, FACHE,
Minneapolis, Minnesota
Michael J. Ojeda, FACHE,
Flower Mound, Texas
Margaret Owens, FACHE,
West Haven, Connecticut
Martina A. Parauda, FACHE,
Edison, New Jersey
David A. Pattillo, FACHE,
Fayetteville, North Carolina
Patricia D. Richardson, EdD,
FACHE, Fresno, California
Fernando O. Rivera, FACHE,
Silver Spring, Maryland
Kathleen Salazar, FACHE,
Houston, Texas
Lisa J. Simoneau, FACHE,
Philadelphia, Pennsylvania
Pamela G. Smith, FACHE,
Huntington, West Virginia
William J. Warren, FACHE,
Morgan Hill, California
Douglas Williams, FACHE,
West Seneca, New York
John R. Woynicz, FACHE,
Kearneysville, West Virginia

ACHE congratulates all affiliates who advanced to Fellow during the 2009 Convocation year. Please visit the Credentialing area of ache.org for a complete list of new Fellows.

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The Power of Pharmacy

How Leveraging Pharmacy Can Benefit Health System Employees and Expand Community Outreach

“As we look to build healthier communities by expanding the care continuum for the 5.5 million people in North Shore–LIJ Health System’s service area, we will be offering consumer health and wellness services such as retail pharmacies.”

Charles Trunz III

President and Founder, VivoHealth, Inc.,
Great Neck, N.Y., a division of the North Shore–Long Island
Jewish Health System

Hospitals are continually looking for ways to improve their financial profiles. Reducing costs and growing revenue have become mission critical, especially during these challenging economic times. One area in which hospitals can grow revenue is by expanding pharmacy’s role within their organizations and within the community.

Traditionally hospitals have produced revenue from established inpatient pharmacies. Another growth opportunity is via outpatient, community-based, ambulatory pharmacies. These opportunities not only provide revenue for a hospital or health system, but they also provide a valuable service to the communities in which they reside.

Keeping Communities Well

One healthcare provider that is working to develop a comprehensive ambulatory pharmacy strategy and presence is the North Shore–Long Island Jewish (LIJ) Health System. North Shore–LIJ has partnered with AmerisourceBergen and

plans to open an initial pharmacy in June in its largest tertiary hospital, North Shore University Hospital in Manhasset, N.Y. The system also is beginning work on a second location at another facility within the health system, its Center for Advanced Medicine (an ambulatory facility).

The decision to open the ambulatory pharmacy as an accommodation to its patients—whether inpatient or outpatient—is in line with the health system’s commitment to building a healthier community, says Charles Trunz III, president and founder of VivoHealth, Inc., Great Neck, N.Y., a division of the North Shore–LIJ Health System. The system includes 14 hospitals and has a service area that includes nearly 5.5 million people in a densely populated metropolitan area in Long Island, Queens, Brooklyn and Staten Island.

“As an organization, we are committed to building a healthier community, and that means extending services across the entire care continuum,” says Trunz. “Delivering and supplying retail pharmaceuticals to manage illnesses—whether they be chronic or systemic or episodic—is a part of the North Shore–LIJ’s mission to provide new care and wellness services to our patients.”

Gregory Shaeffer, managing director, Solutions Group, AmerisourceBergen, says the ambulatory pharmacy strategic plan North Shore–LIJ envisions will be part of its overall goal to move beyond traditional outpatient pharmacy into long-term care, infusion services, chronic disease management programs and more.

“North Shore–LIJ has a strong vision of ensuring patients are being taken care of and are—at all levels of care—connected to the health system,” says Shaeffer.

Other outpatient pharmacy revenue opportunities health systems can explore include pharmacy-based chronic disease clinics and medication management clinics (for Medicare-eligible patients). At chronic disease clinics, pharmacists manage patients with chronic diseases such as diabetes. They treat Medicare-eligible patients but can expand management to other patients as well. These types of clinics provide services that are reimbursable clinical services, says Shaeffer. They also add another valuable service to the health system: Because health system employees can be enrolled in such programs, employee health and wellness overall can improve. This has a direct impact on presenteeism and absenteeism among employees. All these factors have an effect on the system’s ability to deliver quality care cost effectively.

Benefiting Employees

North Shore–LIJ’s plan to build an ambulatory pharmacy will not only benefit the community by providing a convenient option where patients can fill needed prescriptions, but it also will benefit North Shore–LIJ’s own employees and their eligible family members who will have access to the pharmacy.

At the same time, the pharmacy becomes a revenue generator for the health system. Accessing drugs and purchasing pharmaceuticals through group purchasing organization (GPO) agreements for the employee prescription plan creates a significant cost savings opportunity for a health system, according to Shaeffer.

“There is an opportunity through GPO pricing to provide drugs to employees and eligible members of their families,” he says. “Being able to offer this pricing as an employee benefit is a cost savings for a health system.”

The health system saves money with the program, and, at the same time, some of the savings can be passed on to employees. The competitive pricing gives employees an incentive to use the health system’s pharmacy.

North Shore–LIJ is looking forward to being able to provide such a benefit to its 38,000 employees, many of whom have regular pharmaceutical needs, says Trunz. He notes that due to the nature of his medical staff’s long hours, it will be a great convenience to them as well.

“Our retail pharmacies in select locations will be an accommodation to our employees, many of whom do not have time to go to a local pharmacy because they are so busy taking care of patients,” he says. “They work anywhere between 10- and 12-hour shifts.”

Though the pharmacy isn’t set to open until June, Trunz says his employees are excited about the prospect. “We wouldn’t have pursued this opportunity if our employees weren’t engaged and looking forward to providing and accessing these services,” he says.

Looking to the future, health systems can expand their ambulatory pharmacy clinics even further into the community by building pharmacy benefit management programs with other local employers.

“People are going to be spending less time in the hospital and more time at home managing their chronic illnesses and visiting ambulatory sites when periodic examination or testing and follow up are required,” says Trunz. “Delivering and accommodating our patients and consumers with pharmacy services are an important part of the care we deliver.”

For more information, contact Vicki Cooney, vice president, Market Development, AmerisourceBergen, at (610) 727-7052 or vcooney@amerisourcebergen.com.



John M. Buell

Ethics and Leadership

Setting the right tone and structure can help others in their decision making.

Healthcare executives regularly encounter a variety of ethical issues—from organizational issues, such as interactions with suppliers, to the complex clinical issues of end-of-life patient care decisions. To ensure these wide-ranging ethical decisions are being made effectively and in the best interest of patients, employees and the community, healthcare leaders need to set the ethical tone of the organization.

Leaders can begin by establishing a systematic approach to ethics so when ethical issues do occur, the organization's actions to address them match its core values. To do this, leaders should identify and discuss specific ethical challenges, determine how to approach them and provide practical insights to help maintain and enhance ethical performance.

These were some of the recommendations given at a recent program funded in part by the American College of Healthcare Executives' philanthropic initiative the Fund for Innovation in Healthcare Leadership. Established in 2006 to bring innovation to the forefront of healthcare leadership, the Fund has made ethics one of its priorities.

The half-day ethics program, titled "Rising to the Ethical Challenges of Healthcare Leadership," was held last fall in conjunction with ACHE's educational cluster in Scottsdale, Ariz., and included ethics experts Paul B. Hofmann, DrPH, FACHE, president of the Hofmann Healthcare Group, Moraga, Calif., and William A. Nelson, PhD, director, Rural Ethics Initiatives, and associate professor of psychiatry and community and family medicine at Dartmouth Medical School, Hanover, N.H.

The program also included two healthcare panelists: Larry E. Volkmar, CEO, Banner Good Samaritan Medical Center, Phoenix, and Ruth W. Brinkley, RN, FACHE, president and CEO, Carondelet Health Network, Tucson, Ariz.

Program presenters and panelists discussed that ethics is about making the right choice in the face of competing values. To tackle ethical challenges successfully, says Hofmann, an ethics leader will display at least the following six specific behavioral traits:

1. Ethically conscious—Have an appreciation for the ethical dimensions and implications of one's daily actions and decisions or, as described by author John Worthley, the "ethics of the ordinary."
2. Ethically committed—Be completely devoted to doing the right thing. Leaders can be aware of a decision's ethical aspects but may consciously disregard or discount them.
3. Ethically competent—Demonstrate what Rushworth M. Kidder, PhD, president and founder of the Institute for Global Ethics, calls "ethical fitness," or having the knowledge and understanding required to make ethically sound decisions.
4. Ethically courageous—Act upon these competencies even when the action may not be accepted with enthusiasm or endorsement.
5. Ethically consistent—Establish and maintain a high ethical standard without making or rationalizing inconvenient exceptions. This means being able to rebuff the pressures to equivocate, to accommodate and to justify an action or a decision that is ethically flawed.
6. Ethically candid—Be open and forthright about the complexity of reconciling conflicting values, be willing to ask uncomfortable questions and be an active, not a passive, advocate of ethical analysis and ethical conduct.

In addition to demonstrating ethical leadership in one's actions and decisions, the presenters emphasized that

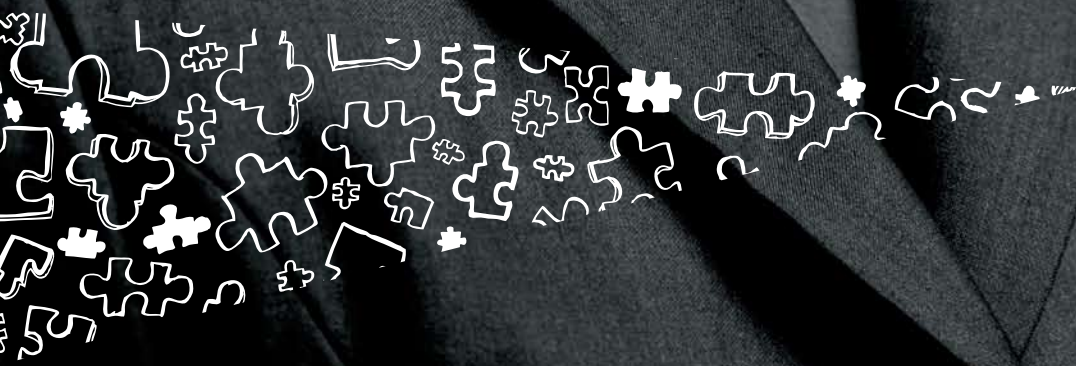
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healthcare leaders must establish, support and use a comprehensive ethics infrastructure in their organizations.

Traditional ethics programs tend to be case-based, reactive, and clinically and inpatient focused, says Nelson. They tend to lack an organizational focus and system-oriented approach. Furthermore, adds Nelson, traditional ethics programs accept the recurring nature of ethical conflicts with detrimental effects on the organization such

as diminished quality of care, poor patient satisfaction and public relations, increased cost and lower staff morale.

Nelson says ethics programs should evolve to better establish ethical healthcare practices throughout the organization, educate staff regarding ethical behavior and evaluate the implementation of ethical practices. In addition, an effective ethics infrastructure should address the expanded healthcare environment

and apply a proactive approach—using quality improvement methods for enhancing both clinical and administrative ethical practices.

To foster an ethical organization, Nelson recommends developing, implementing and regularly reviewing the organization's mission, value statement and code of ethics, which guide planning, decision making and employee actions. Also critical are building an ethical culture through

Ethics Awareness

Following are three under-recognized ethical issues you may not have thought about:

Promoting Unrealistic Expectations

Like any other organization, a hospital or health system wants to present to its community a positive image. But if it unintentionally creates a perception on the part of the public that it can do more than it can deliver, that is a disservice to the community and to the people who trust the organization.

“This is disingenuous at the very least, even if the objective is well intended,” says Hofmann. “Our institutional credibility and integrity both within and outside the organization are at risk if we do.”

Healthcare organizations that overpromise and underdeliver do so mainly because of competitive reasons. By being overzealous, organizations can create certain expectations. “It's better to

underpromise and overdeliver,” says Hofmann.

Rationalizing Inappropriate or Incompetent Behavior

All levels of the organization—board, management and medical staff—should focus on this issue. It is difficult and sometimes painful to deal with individuals who are behaving or performing in a way that is inappropriate, whether it is sexual harassment or someone who is not managing his or her staff effectively.

Tolerating inappropriate behavior or incompetency can cause variations in medical care, which can have a detrimental effect on quality of care and patient safety, says Hofmann. Tolerance also sends the message to staff that inappropriate behavior and incompetency are acceptable. “The stress on employees can be seen in missed time at work and staff turnover,” he says.

Failing to Acknowledge Mistakes

When mistakes are made in healthcare organizations, lives may be at risk, according to Hofmann. Until mistakes are admitted, they cannot be corrected and prevented from occurring again. In cases of medical errors, they need to be disclosed to patients and their families, an apology must be given and the steps that will be taken to avoid similar mistakes must be outlined and communicated.

Ethical mistakes, says Hofmann, are not intentional, but healthcare managers are sometimes guilty of creating the illusion that because they are managers they have all the answers. By demonstrating proper humility, you can and should acknowledge your fallibility when a mistake is made.

employee selection, orientation and performance evaluation and providing staff with venues to discuss and resolve ethical concerns and conflicts.

Another key step, according to Nelson, is development of a fully integrated ethics committee with stronger ties to the organization's leadership, a broader scope, more visibility and greater accountability. With these ethics strategies, he says, "instead of putting out fires, healthcare leaders are more likely to prevent fires from ever starting."

With processes and procedures in place, leaders and staff will have the tools to make effective decisions no matter what the ethical circumstance.

Ethics Resources

The presenters pointed to ACHE's ethics resources as a means to support the development of an integrated ethics approach in healthcare organizations. Affiliates of ACHE commit to upholding ACHE's *Code of Ethics*. In addition, ACHE's Ethical Policy Statements, which can be found on ache.org, present ACHE's position on various ethical issues in healthcare and suggest a guideline of behavior. Topics include the following:

- Considerations for Healthcare Executive-Supplier Interactions
- Creating an Ethical Environment for Employees
- Decisions Near the End of Life
- Ethical Decision Making for Healthcare Executives
- Ethical Issues Related to a Reduction in Force
- Ethical Issues Related to Staff Shortages
- Health Information Confidentiality

- Impaired Healthcare Executives
- Promise-Making, Keeping and Rescinding

ACHE's Ethics Self-Assessment is designed to help healthcare executives identify those areas in which they are on strong ethical ground; areas in which they may wish to examine the basis for their responses; and opportunities for further reflection. It does not have a scoring mechanism, as ACHE does not believe that ethical behavior can or should be quantified.

By setting the tone that ethics is a key component to quality healthcare, healthcare leaders send a clear message that ethical performance is valued more than individual and organizational self-interest

and achievement. Furthermore, by putting systems and resources in place to support ethical decision making, healthcare leaders demonstrate and empower others to act accordingly. ▲

Note: ACHE's next ethics program, funded in part by the Fund for Innovation in Healthcare Leadership, will take place Aug. 5, 2009, at the New York Cluster. Visit ache.org seminars for more information. To learn more about the Fund, please turn to page 26, visit ache.org innovation, or contact Laura Wilkinson, assistant director, Development, at (312) 424-9305.

John M. Buell is a writer with Healthcare Executive.

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Gail Scott

Leading in Hard Times

Successful strategies to ensure employee commitment and loyalty in times of change.

For leaders adept at managing change, the current healthcare environment represents vast opportunities. Change, however, even in positive circumstances, can be hard on employees. Leaders who maintain a “business as usual” approach in the present environment may find patient care and staff morale suffering. Today’s healthcare executives must adopt a holistic approach to leadership—one that garners employee commitment and confidence while achieving the necessary systems improvements to support a new direction.

Following are concrete strategies for successfully managing people and relationships while promoting change and successful outcomes in turbulent times.

Set a Positive Direction

People today are fragile—worried about their futures and starved for direction and solutions. Priority No. 1 for leaders is to create a positive vision for the organization and back it up with tangible goals and specific strategies that inspire people to get on board. To this end, leaders must focus on the positives and highlight what *is* working. They also must share the new direction and clarify strategies with employees at

all levels of the organization to generate buy-in and support, knowing that success depends on everyone’s full participation.

Priority No. 1 for leaders is to create a positive vision for the organization and back it up with tangible goals and specific strategies that inspire people to get on board.

We may not have a crystal ball to predict the future, and with all of the economic uncertainty we do not want to create unrealistic expectations, but we can help people see what is possible, providing transparency, direction, hope and commitment to a successful future.

Communicate Extensively

When times are tough, excellent communication becomes even more critical. Old-style, one-way approaches will not work. Instead, create a new sense of accountability and insist that everyone:

- Stays informed and informs others

- Intervenes on behalf of the system to clear up rumors and misinformation
- Challenges negativity and shares positive facts related to what is really happening
- Attends meetings and/or is responsible for related outcomes

This is indeed a shift in thinking and behaving. To set the stage:

- Round daily to spread positive energy and facts
- Use multiple strategies to take the pulse of the organization such as surveys, hotlines and focus groups
- Create safe environments for people to speak up, ask questions and get the information they need to be a true partner and asset

Warning: Words count for only 30 percent of interpersonal communication. Body language and tone of voice convey the rest. We need to be mindful of this in all conversations to make sure we are sending the correct messages.

Promote Learning, Growth and Change

When times are tough, education may be the first casualty. In today’s

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world, education could not be more critical. Healthcare needs will continue to grow as our population ages, and leaders should be proactive, looking at the jobs, skills and mind-sets needed to meet changing demands. To this end:

- Get to know employee skills and interests
- Find ways to match employee skills and interests with current opportunities
- Provide ongoing education and training to ensure a work force that meets future needs

Beyond providing formal education and training, we need to create a coaching culture. The goal is to build a learning environment, focused on personal mastery, where everyone has something to share, and everyone has something to teach. Feedback, storytelling, observation and buddy systems are just a few of the ways to begin instilling coaching habits in your managers and staff.

Build Life Skills

We tend to think about clinical and technical needs when considering learning opportunities, but equally important in today's environment are the emotional and physical needs of staff. Our work force is under tremendous pressure, and this turmoil can impact the care we give to patients and each other. It makes good business sense to support staff by offering:

- Educational health/nutrition forums
- Reduced rates at fitness centers

- Free health screenings
- Stress maintenance technologies and techniques

Helping staff with issues such as personal financial management or dealing with an out-of-work spouse, troubled teens, or aging parents, etc. also can be very beneficial. The point is, the better people feel about themselves, their skills and abilities, and their life situations, the more they will have to give to others, and the less resistant they will be to change.

The goal is to build a learning environment, focused on personal mastery, where everyone has something to share, and everyone has something to teach.

Warning: Whether we're talking about formal education and training or building life skills, we need to insist on greater employee ownership and accountability. Staff members must participate in identifying what they need to learn and then take advantage of the resources available. We need everyone's full attention and involvement if we are to succeed in these troubled times.

Achieve and Report Results

There is bound to be skepticism in times of great change, yet the greatest way to counter negativity and fear is by achieving and sharing results. To build a positive, "can do" mind-set:

- Involve all levels of the organization in creative problem solving
- Establish clear timelines and simple measurement techniques
- Start every meeting by reporting successes
- Post scores and achievements so people can see them
- Provide bullet points of system-wide successes and updates for managers to share in weekly meetings and daily huddles

We need to be vigilant and watch for developments during times of change and stress, and we need to use the information to make immediate course corrections. Every plan has its upsides and downsides; we can turn a downside into a positive learning experience if we act quickly.

Strengthen Teamwork

None of us could get our jobs done without the help and support from others in our teams and systems. We need to build and celebrate healthy workgroups and make sure all leaders receive tools and support to keep this focus alive. When times are tough, people can rally together or take it out on each other. We must have the former. To eliminate disruptive and hostile behavior:

- Create clear codes of conduct
- Insist on zero tolerance for noncompliance
- Provide training opportunities for staff to learn healthy ways to hold challenging conversations

Most important, we need to take precious moments to give thanks to each other and structure ways for teams and groups to celebrate the journey together.

Celebrate the Spirit of the Organization

Most people enter the healthcare field because they want to make a difference. When times are tough, we can appeal to this need to serve and reflect on ways our jobs have a positive impact. Spiritual councils, enrichment days, spiritual coaching and support networks can certainly help, but leaders also can bring positive energy into their own teams using simple techniques:

- Start meetings with hero stories about outstanding staff actions
- Allow patients to share their stories about how they benefited from the care they received
- Arrange for individuals and teams to “give back” and let them share their experiences

The last strategy may be life changing. By focusing on opportunities to give to others in need, people discover how much they have to be grateful for.

Turbulent times necessitate that senior leaders voice a new “call to action.” For an organization to manage change and sustain success, all employees must participate in creating a positive work environment; developing a work force that is ready and able to change and adapt;

establishing healthy partnerships with their peers; and providing unequalled service and quality care for patients. Finally, all employees must commit to living up to their potential. We will only survive and thrive if we are in this together—thinking, caring and being open to the possibilities. ▲

Gail Scott is president of Gail Scott and Associates, Meadowbrook, Pa. She serves as ACHE faculty for several customer service and leadership development seminars, including “The Art of Building Relationships for Successful Teams and Partnerships.” She can be reached at gscott@gailscottassociates.com.



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Creating a Healthier Path for Children

Diabetes program helps children learn to make healthy lifestyle choices.

Many children with Type 2 diabetes are walking a tightrope toward medical disaster. The growing epidemic of childhood obesity in the United States has brought an alarming rise in cases of children with this condition. As the second most common chronic disease of childhood, diabetes can be devastating, costly and even fatal for children if left untreated.

About seven years ago, we noticed a significant increase in the number of children seeking care at WakeMed with undiagnosed and poorly managed diabetes. We also recognized that local resources for these children were extremely limited. Even though Wake County is one of North Carolina's most populated communities, it lacked a pediatric endocrinologist specializing in diabetes, and diabetes specialists in neighboring cities were difficult for low-income patients to access because of barriers such as transportation and insurance.

We felt compelled to address this growing community health issue. WakeMed established a pediatric diabetes program (PDP) in 2003. Originally, the PDP targeted children with Type 1 diabetes, an autoimmune disease resulting in insulin deficiency. However, within one year of the program's inception, PDP's staff noticed a sizeable increase

in the number of referrals for children with Type 2 diabetes. Because Type 2 diabetes can be treated or completely prevented by lifestyle changes alone, we believed that our community needed a creative solution to tackle the preventive aspects of this disease.

The success of ENERGIIZE! can be attributed to the fact that its impact can be measured and evaluated within a relatively short time frame.

Based upon that need, WakeMed's PDP initiated a first-of-its-kind program called ENERGIIZE!, which is designed to teach young people at risk of developing Type 2 diabetes and their families how to build lifelong, healthy attitudes about food, fitness and health. Implemented in 2005 with financial assistance from the Duke Endowment and the John Rex Endowment, ENERGIIZE! is overseen and implemented by WakeMed's PDP staff, including a pediatric endocrinologist, pediatric intensivists, a registered nurse, a registered dietitian, certified diabetes educators and a health education specialist. Our team is supported by educators and fitness instructors from our formal community collaborators

including the Raleigh City Parks and Recreation Department, the town of Cary, the YMCA of the Triangle and other local organizations.

Predicting Risk

ENERGIIZE! targets at-risk patients (and their families) between the ages of 6 and 18, especially Medicaid recipients and the uninsured. A large percentage of these children are from low-income families and ethnic minority populations, who are disproportionately affected by Type 2 diabetes.

Participation in ENERGIIZE! begins with a physician referral and screening lab work. Those children whose results show elevated fasting glucose levels or metabolic syndrome qualify for the program, and their families receive individual assessments by an educator who explains the program and evaluates participants' readiness to change. The information not only helps determine who enters the program but also serves as a baseline for tracking progress over time. This feature makes ENERGIIZE! an innovative program, and it is the only one that we know of that uses a medically based model.

Providing Knowledge

Once accepted, children and their families are enrolled in the 12-week, three-night-per-week intensive education and lifestyle program that includes lessons in nutrition, physical fitness and behavior modification.

This column is made possible in part by Philips Healthcare.

PHILIPS

These components are the foundation of our program. We believe that if we can help these children integrate healthy, sustainable choices into their daily routines—and the routines of their caregivers and families—they can live long, productive and healthy lives. We have made a concerted effort to offer the courses in close proximity to where participants live to make attendance as convenient as possible. To that end, the group sessions take place at various YMCA and park district sites throughout the community and at the PDP facility on the WakeMed Raleigh Campus, a 659-bed tertiary care hospital. Sessions are taught collaboratively by WakeMed clinicians and our partners at each site.

Measuring Success

Follow-up for ENERGIZE! participants begins when they finish the program. Visits are scheduled every six months for two years to obtain body mass index (BMI) results, blood pressure readings, fasting glucose levels and lipid levels and to assess progress via nutrition, physical activity and behavior change goals. Since the program's inception, more than 2,000 children have been referred to the program, 1,500 have completed the screening lab work, and 625 were found to be at risk and thus eligible for the program. Of those 625 children, more than 500 have participated in ENERGIZE! thus far. Six-month outcomes reveal that completing the 12-week ENERGIZE! program helps children with pre-diabetes and Type 2 diabetes adopt healthier lifestyle habits. They include:

- Statistically significant reductions in BMI, low-density lipoprotein (LDL), or “bad” cholesterol, and blood pressure.

- Increases in high-density lipoprotein (HDL), or “good” cholesterol.
- Statistically significant reductions in fasting blood glucose.

In addition, program graduates exercised more and spent less time watching television, playing video games and using the computer six months after completing the program. They also drank more water and fewer sweetened beverages than they had before they enrolled in the course. Creating a medically based program with regular follow-up has enabled us to collect important data and ensure that participants continue to get the support they need to positively affect their health.

In addition to the measurable benefits, a less quantifiable, albeit important, benefit extends to families and caregivers. Although a child's siblings or parents may not have been given the same diagnosis as the child, they will receive the same information about healthy lifestyle choices. They are exposed to the local YMCA and its outstanding community outreach programs. They also become plugged into a health system like WakeMed, with its own extensive and useful resources. As a result, they, too, may avoid a diabetes diagnosis down the road.

Replicating ENERGIZE!

WakeMed's PDP has worked diligently to refine the program and document its components to make it easily replicable in other communities. In early 2007, WakeMed urged the North Carolina General Assembly to appropriate \$250,000 for this effort. By fall 2007, the North Carolina Division of Public Health, Diabetes Prevention and Control

Branch, received applications from and awarded grants to five North Carolina counties to implement the ENERGIZE! program. In fall 2008, five more counties were added. We share our template and concept in a consultative role with other communities, but each county has ownership of its program.

The success of ENERGIZE! can be attributed to the fact that its impact can be measured and evaluated within a relatively short time frame. Simply put, the math of our participants' healthcare turns positive. In addition to transforming the lives of individual members of our community, over time we hope that ENERGIZE! will demonstrate an economic benefit. Currently, 13 percent of all hospitalizations in North Carolina are directly related to diabetes. In Wake County, annual hospital charges for diabetes total more than \$82 million, including 46,591 days of hospital care. Our results thus far demonstrate the preventive and long-term potential of ENERGIZE! to help bring down those statistics.

We clearly recognize the ability of ENERGIZE! to steer children and their families toward a healthier, more hopeful path. For caregivers at WakeMed, the knowledge that our program can have a long-lasting impact brings with it a great sense of professional and personal fulfillment. ▲

William K. Atkinson II, PhD, FACHE, is chief executive officer of WakeMed Health & Hospitals in Raleigh, N.C. He can be reached at (919) 350-8112.



John H. Ferman

SCHIP to Cover More Patients

New law also allows states to accept even more children into program.

It is important for healthcare executives to understand the role the newly signed State Children's Health Insurance Program (SCHIP) plays in meeting the healthcare needs of the uninsured, even though much of the spending goes to professional providers.

Labeled P.L. 111-3 and signed into law in February, the State Children's Health Insurance Reauthorization Act of 2009 provides \$32.8 billion extra during the next four-and-a-half years. Lawmakers expect SCHIP expansion will allow coverage to about 11 million children, an increase from roughly 7 million in 2008. Still, nearly 9 million children remain uninsured—most of whom are eligible for Medicaid or SCHIP but are not enrolled.

SCHIP, a joint federal and state program, was created in 1997 to provide health insurance to children of low-income families that are not poor enough to qualify for the larger Medicaid program. Initially funded at \$40 billion to be spent over 10 years, SCHIP has been credited with reducing the number of children in the United States without health insurance. Today, one-quarter of children in the United States and half of all low-income children receive their health coverage through Medicaid or SCHIP. Medicaid covers 29 million poor and near-poor children.

With their control of Congress and a Democrat in the White House, the Democratic majorities have used their political muscle to add provisions to the bill to expand the program. For instance, Democrats removed a five-year waiting period for legal immigrants to enroll in SCHIP or Medicaid. They also loosened citizenship and eligibility documentation requirements, which advocates for the poor say have deterred some legal, qualified families from enrolling. And Democratic senators adopted an amendment that would allow parents to enroll children in SCHIP or Medicaid without signing any documents.

In addition to covering physician visits, immunizations, hospitalizations and emergency room visits, the expanded bill also will include dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions. And state programs with children's health insurance that provide disorder or substance abuse benefits must be on par with the respective program's medical and surgical benefits.

SCHIP's expansion will be largely funded through a 62-cent increase in federal taxes on cigarettes, bringing the tax to \$1.01 per pack.

The expanded bill will increase coverage to 300 percent from 200 percent of the federal poverty level, while allowing states to go even higher, and will limit the federal matching rate for any expansion above this level.

One provision of the bill that fell to the wayside, for now, was contained in the initial House-approved version that was sent to the Senate. This provision would have closed a loophole in the physician self-referral law (known as the Stark law) that allows doctors to refer Medicare patients to hospitals in which they have ownership interests and would have imposed a one-year moratorium on new physician-owned hospitals. In addition, the provision would have required that physicians divest themselves from their investments in hospitals. These are just two of the factors that may have led to the Senate's decision to drop this provision. It is expected, however, that the provision will appear in future healthcare legislation. One such measure needs to be enacted by Jan. 1, 2010, to avoid a 21 percent physician fee reduction.

Healthcare reform will likely not come in one complete universal health reform package but will, over time, be pieced together. This will include expansion of Medicare, Medicaid and SCHIP programs, each with its own constituencies that will do everything to protect and expand its respective programs. ▲

John H. Ferman is principal at Health Policy Alternatives Inc. in Washington, D.C.

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J. Craig Honaman,
FACHE

Managing the Electronic Job Search

Making a good first impression via e-mail is as important as face-to-face.

The most common method of distributing résumés today is by e-mail, and job searchers now must have firm control of the electronic distribution process—a process that can be difficult to manage.

The new variables involved in electronic résumé distribution require increased time, commitment, attention to details and familiarity with how the electronic process works. If you have not conducted a job search in the past 18 months, seek advice and suggestions on preferred methods. The learning curve may waste valuable time.

The documents transmitted represent a test of the applicant's communication skills; they should be well written. Furthermore, the transmission process itself is a reflection of the candidate's computer skills and awareness of current technologies. Diligent attention to relevant details will be effective in making a positive "first impression."

Here are some suggestions to enhance the electronic résumé transmittal process.

Use Prevailing Software

The résumé and cover letter should be created in Microsoft Word. Do not use a PDF file format or a PowerPoint slide presentation. If the software is a newer

version of Office, such as Office 2007, convert the document to an earlier version of Word so it is compatible with a higher proportion of users' computers. If the document cannot be opened, it will be ignored. Because millions of computers still operate using earlier Office versions, do not take a chance that the recipient has the most up-to-date tools to view the document.

Identify Proper Recipient

A dichotomy has emerged as the submittal process has become more electronic: Even while the application process has become essentially faceless, you, the sender, still need to develop some personal relationship with someone in the organization. People are hired based on these relationships, so it is best to have strong connections in the industry and the organization. Meanwhile, due to time constraints and the fact that perhaps hundreds of candidates are applying for positions, both the organization and search consultants aim to have very little personal contact with applicants. Research to identify a person to whom the cover letter should be addressed is essential, especially if you have available only an organization name and e-mail address. Internet research about the organization and telephone calls to its HR department often help you uncover the correct person. Using a generic "to

whom it may concern" approach is an easy way to get yourself deleted. Be aware that search firms often use only generic e-mail address connections.

Ensure Deliverability

Did the document file arrive? The only way to know is to ask the recipient or to request a notice to verify arrival. Spam filters or other electronic diversion applications may prevent your e-mail from arriving. Résumés can be caught as spam mail and held up by the spam filters in some Internet service providers. The document is moved into a spam file before the recipient has a chance to see the message. Often, no one knows the file is being held unless you alert the addressee that it was sent. Knowing the appropriate person to whom to address the cover letter comes in handy in this process as well.

Craft an Effective Cover Letter

Address the letter to a specific person. Ideally, previous contact has been made at the organization to develop some relationship, facilitating the application process. A one-page cover letter is preferred.

Transmittal of the letter is best conducted as the first part of a single file that also contains your résumé. This allows the recipient to avoid having to open two separate files and prevents the possibility of the files becoming separated and difficult to find. Make the process for the recipient as easy as possible. Other options include embedding the letter as part

.....
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Because health matters

of the e-mail text or as a separate attached file.

The document should be carefully structured to create excitement about you and to encourage the addressee to review your résumé. Be concise and succinct, and make sure that the letter is devoid of spelling and grammar errors. Avoid the word “I” as much as possible—the reader already knows who the letter is about.

Build the Ideal Résumé

The résumé must be well written, support accomplishments with hard-hitting metrics and clearly articulate your “brand.” First impressions count. As mentioned above, the résumé is a test of written communication skills

and will be evaluated in a very short period of time on the first review.

Hone the E-mail Subject Line

Give the recipient an exciting reason to want to open the e-mail. Conduct a spell check, but also be sure to review your subject line language carefully because electronic spell checking does not check the subject line text. A misspelling here will create a significant barrier to your success in gaining the position.

Consider the File Name

Make it easy for the recipient to find the downloaded file in his or her computer file directory. Label the file with your name and the word “résumé.” Using short names

or abbreviations could make it difficult to find. The easier it is to find your résumé, the better.

Manage Your Historic Archives

People often store résumés electronically for long periods of time. If updated résumés are developed, have a method of identifying the different versions. It could include using a code on the document that can be identified easily.

Monitor Electronic Postings

Use résumé bulletin boards with caution. Any posting will become outdated, so the board should have the capability of updating documents. Be sure to monitor the posting periodically. Your information may be forwarded to other

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electronic sources, so you generally lose control over where your résumé is sent. While such forwarding may produce a valuable contact, it may also be problematic. If a person calls to talk about a prospective position based on viewing your résumé from a posting, be sure to verify the caller's position with the company before revealing any personal

information that is not on the résumé to protect against identity theft.

Supplement Electronic Applications

Most job applications do not fully replace the résumé. The résumé provides more detail of accomplishments and allows you to describe your brand. Whenever possible, include

the résumé in an application or send it separately to the contact person.

Be Connected

The American College of Healthcare Executives Affiliate Directory is a great resource to aid in learning about your network contacts. Sharing work experience and displaying degrees and credentials can help you develop a commonality for relationship building.

LinkedIn, Plaxo and other networking Web sites are valuable tools to connect with other professionals. Remember, you may be examined by recruiters online. Use the sites for professional purposes only, and enter information that will help you connect with other people. Conversely, searching people's names on Google can often uncover information about people that may be helpful when determining to whom to send your résumé.

Make no assumptions about the electronic résumé submission process. Verify all actions taken with personal contacts. A job search can be enhanced with help from a mentor or coach. Use all the resources available to you to improve your chances of early engagement.

Job searching will continue to evolve with the electronic connection processes. Seek advice early from those who are attuned to electronic trends to stay up to date with the market requirements. ▲

J. Craig Honaman, FACHE, is principal at H & H Consulting Partners LLC in Atlanta. He can be reached at (770) 394-2221 or careerdir1@aol.com.

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Official Notice for the 2009–2010 Council of Regents Elections

This official notice serves as the beginning of the election process to select new Regents to serve on the American College of Healthcare Executives' Council of Regents, the legislative body that represents ACHE's 30,000 affiliates. Service as an elected official is a unique opportunity to exercise your leadership ability, share innovative ideas and act on behalf of fellow affiliates.

All Fellows who wish to run for election must submit either a letter of intent to ACHE via certified mail postmarked by September 4, 2009, or an electronic letter of intent to elections@ache.org. If you submit your letter of intent electronically and you haven't received confirmation by September 7, 2009, contact Mya N. Jones at (312) 424-9324 or mjones@ache.org.

Please note:

- New Regents will each serve a three-year term on the Council of Regents beginning at the close of the March 2010 Council of Regents meeting during ACHE's annual Congress on Healthcare Leadership.
- Affiliates are assigned to a Regent jurisdiction based on their business address.
- This official notice is the only notification for the 2009–2010 Council of Regents elections.

If you would like additional information about the responsibilities of a Regent and what you need to submit your letter of intent, please contact Mya N. Jones, Division of Regional Services, at (312) 424-9324.



ELECTIONS WILL BE HELD IN THE FOLLOWING JURISDICTIONS:

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Maine
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South Dakota
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Utah
Veterans Affairs
Washington
West Virginia
Wisconsin
Wyoming



Are You Ready for Greater Transparency and Accountability?

More regulatory requirements and greater public awareness spark movement.

Dramatic and rapid market and regulatory changes are stimulating fundamental shifts in the nature of governance and leadership in healthcare organizations. These changes are shining a spotlight on board practices and accountability and requiring work at levels of depth and detail significantly different from the past. In this environment, hospital CEOs and their boards must be able to answer the question: How ready are we to meet these challenges and to stay ahead of the accelerating curve of regulatory requirement and public scrutiny?

Heightened governmental scrutiny of nonprofit organizations, including hospitals, has given rise to a number of new and proposed requirements for healthcare organizations and their governing boards.

The newly effective IRS Form 990 requirement, which must be filed beginning this year, calls for unprecedented governance transparency. Nonprofit organizations are required to:

- Have greater director independence and the ability to demonstrate how many independent directors there are among the total number of voting board members.

- Make available to the public governance documents, including bylaws, board policies and financial statements.

Do we have in place up-to-date policies on issues such as whistle-blower protection, document retention and joint ventures? Are board policies and other documents such as bylaws and financial statements publicly available?

- Determine CEO, other top executive and key employee compensation based on independent board members' review and approval, using comparability data and documentation of board deliberation and decision making.
- Establish conflicts of interest policies and processes, including filing annual disclosures and determining whether trustees and key employees have business or family ties to the organization.
- Create policies that protect whistle-blowers, address retention and

destruction of corporate documents and ensure independent board member participation in oversight and decision making about joint ventures.

- Demonstrate that the full board reviewed Form 990 prior to filing.

Sen. Charles Grassley (R-Iowa), a member of the U.S. Senate Finance Committee, told *The Wall Street Journal* that boards are worthy targets. "In my experience reviewing charities that have failed their mission, poor board governance unites them all," he said. The Dec. 18, 2008, article, titled "Grassley Targets Nonprofit Hospitals on Charity Care," discussed proposed legislation early this year that would hold nonprofit hospitals more accountable for their tax-exempt status by:

- Requiring minimum expenditures on charity care, such as 5 percent of patient revenue
- Imposing a new excise tax on private-benefit transactions such as excessive executive compensation or contracts tainted by conflicts of interest
- Imposing penalties such as escalating taxes, fines and loss of tax-exempt status

- Considering fines on executives and board members

This proposed legislation clearly indicates a strong focus not only on meeting standards, but also on accountability for performance failure.

The Joint Commission also is getting tougher on hospital leaders and boards by developing a new standard on conflicts of interest that became effective in January of this year.

With all of this pressure on governance transparency, performance and accountability, how are non-profit organizations measuring up? The results of Grant Thornton's *2008 National Board Governance Survey for Not-for-Profit Organizations* provides some insight. Respondents included 652 CEOs, CFOs, board members and other senior officials from a variety of nonprofits, including healthcare organizations, across 42 states. The survey indicated that:

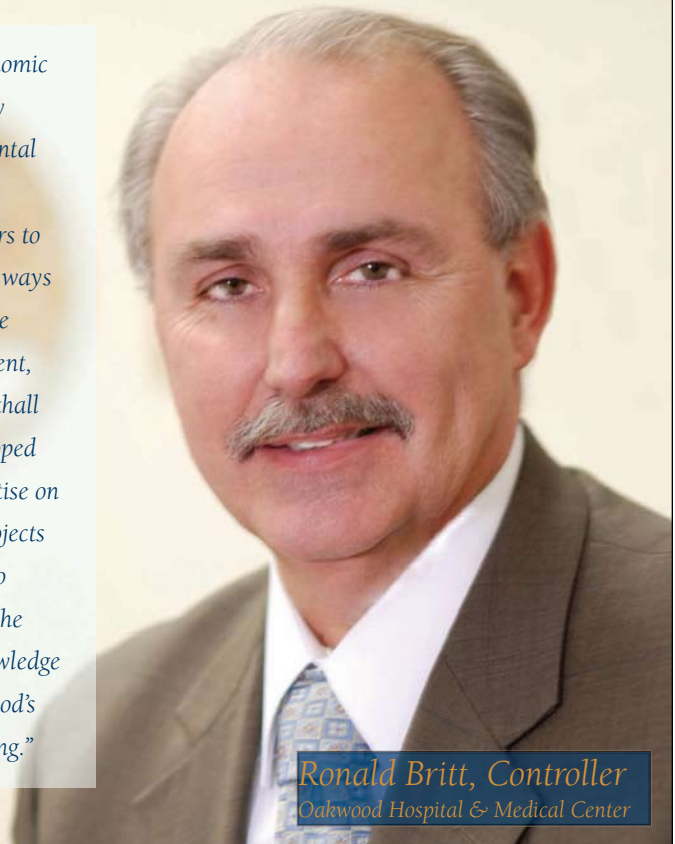
- Ninety-two percent of respondents' organizations have conflicts of interest policies in place, 81 percent have records-retention policies in place and 71 percent have whistle-blower policies in place.
- Eighty-seven percent of respondents' organizations have a revised investment policy in place and 50 percent have an investment committee of the board.
- Seventy-one percent of responding organization boards

or board committees are meeting once a year to discuss executive management compensation and benefits, and 68 percent document discussion and approval of executive compensation and benefits in the board or board committee minutes.

- Seventy-four percent of respondents report their organizations have an audit committee in place.
- Forty-five percent of respondents said their organizations have a policy in place for board review of the Form 990/990T.

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To help determine their readiness to meet these emerging governance and leadership challenges, CEOs and their boards can ask the following questions:

- Does our board have in place an up-to-date conflicts of interest policy? Does it define what a conflict is and how conflicts will be addressed?

How often do we consult our policy during meetings of the board? How frequently are disclosures filed?

- Do we have in place up-to-date policies on issues such as whistleblower protection, document retention and joint ventures? Are board policies and other documents

such as bylaws and financial statements publicly available?

- Does our full board review Form 990 before it is filed? Do we post it on our organization's Web site?
- How frequently does the board review executive compensation? Are the board's deliberations and decisions documented? Are only independent board members involved in the discussion and decision regarding executive compensation?
- Does our board have an audit committee? An investment committee?
- How much does our organization spend on charity care? How do we document and communicate the level of community benefit our hospital provides?

CEOs and boards that work together to answer these questions will not only be prepared to more confidently address current governance and leadership challenges, but they also will strengthen their ability to stand up to new demands and requirements likely to emerge in the increasingly dynamic healthcare environment. ▲

James E. Orlikoff is senior consultant and Mary K. Totten is director of content development for the Center for Healthcare Governance, a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in healthcare governance.

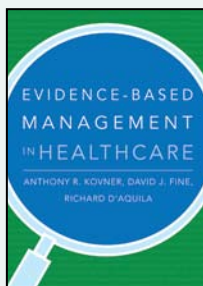
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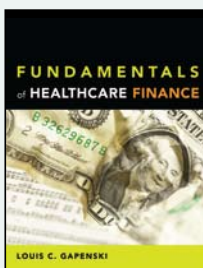
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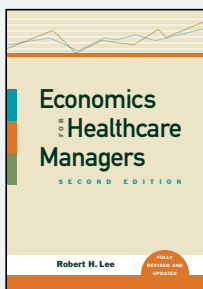
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What Students Think

The surgical safety checklist and the ICU walker.

Almost every year, IHI President and CEO Donald Berwick, MD, gives a lecture about quality improvement to first-year medical school students at Harvard. Though the lecture takes place right after lunch—a low point of the day—by the end of class everyone is wide awake.

This is just one example of a new energy taking hold among health professions students. They are excited by new exposure to the principles of quality and safety in healthcare and feel encouraged by organizations that welcome students onto their improvement teams. I am one of those students. In just a few months, I will be starting medical school after working for nearly a year at IHI, learning and applying these quality improvement principles as Dr. Berwick's special assistant.

Looking at healthcare with the tools of quality improvement is like putting on a new pair of eyeglasses. As a soon-to-be medical school student, I feel lucky to have received my glasses early. Indeed, I am often struck by how accessible and commonsensical many of the processes that lead to better patient care really are. Below are two examples of these processes—one of which was created by students.

The Surgical Safety Checklist

Years of psychological and behavioral research have proven that people are fallible. As hard as we try or as much as we hate to admit it, human errors are bound to happen. So, why pretend they never happen, especially when some kinds of errors endanger others and can lead to dire consequences? Several industries have transformed themselves with human errors in mind. The airline industry is a favorite example. As a result of aircraft design, regulation, the use of checklists and other systems designs, we are almost guaranteed to reach our final destination safely. According to data collected between 2000 and 2005, the chance of a fatality on a domestic airline flight was one in 22.8 million.

Healthcare is slowly following in the footsteps of the airline industry. Many processes are being redesigned to absorb human errors and make safe execution the only option. At IHI's 20th Annual National Forum last December, Dr. Berwick and noted surgeon and author Atul Gawande, MD, made an announcement about the enormous potential of the World Health Organization (WHO) Surgical Safety Checklist to save lives. Research published in the *New England Journal of Medicine* suggests that implementation of the checklist can reduce

inpatient complications and prevent deaths. In a one-year pilot study conducted in eight locations across the world, inpatient complications were reduced from 11 percent to 7 percent, and the rate of death declined from 1.5 percent to 0.8 percent.

Several industries have transformed themselves with human errors in mind. The airline industry is a favorite example. As a result of aircraft design, regulation, the use of checklists and other systems designs, we are almost guaranteed to reach our final destination safely.

Here are some more facts to consider: It is estimated that 234 million operations are performed globally every year. With the observed reduction in inpatient complications and deaths, the checklist could prevent nearly 9.4 million complications and 1.6 million deaths (by IHI's calculations). Notably, the Surgical Safety Checklist is a one-page document with 19 steps—an inexpensive intervention that is readily adoptable—that has amazing potential to save lives.

The ICU Walker

Getting intensive care patients out of bed and walking is another area that has been ripe for innovation. Research conducted by Dale Needham, MD, PhD, of The Johns Hopkins University School of Medicine, has demonstrated that ICU patients benefit from getting out of bed and walking from time to time. These benefits include preventing muscle atrophy, improving lung function and even decreasing the length of ICU or hospital stay. But this is not an easy task. Most ICU patients are weak and depend on several life-support devices. The current process just to prepare for walking takes 40 minutes and two nurses and probably causes patients great dissatisfaction. Besides walking with the chaos of cords and wires at your side, this kind of venturing out of bed requires a respiratory therapist and someone to follow the patient closely with a wheelchair in case the patient slips or needs to sit down immediately.

This process clearly needed some systems redesign. Accepting the challenge were eight biomedical engineering undergraduate students at The Johns Hopkins University. They decided to design a walker that would allow ICU patients to get out of bed and walk around safely. Joshua Lerman and his team first conducted some research and collected about 50 objectives from doctors, nurses and patients—including safety of the innovation, ease of use, comfort and maintenance. The walker also had to be self-contained, accommodate several medical devices and fit in typical hospital corridors. Most

importantly, patient safety was the primary objective.

Health professions students are unwilling to accept adverse events and inefficiencies as inevitable characteristics of the healthcare system.

After several draft ideas, including large adjustments to avoid stress on the wires connecting the patient to medical equipment and minute design details to use cloth strong enough for the built-in seat of the walker, Lerman and his team finalized their design. The ICU walker, more formally known as the ICU Mover Aid, consists of two parts: (1) a streamlined tower that consolidates all necessary life support equipment and (2) a walker/wheelchair combination.

The final product reduces the chaos of several life support devices attached to the patient, making it safer to walk, requires only a respiratory therapist to monitor and walk with the tower and a physical therapist to stand behind the patient and walker, and can be easily maneuvered through typical hospital corridors. The ICU walkers are now in use at Johns Hopkins. From student innovation to standard hospital equipment—now that's inspiring.

Health professions students, like me, are unwilling to accept adverse events and inefficiencies as inevitable characteristics of the healthcare system. We want to get our hands dirty and

work together across disciplines to make remarkable changes to improve hospital processes and do exactly what led us to healthcare in the first place—heal patients.

And if *you* are impatient for change, we students are even more so. No sooner had the WHO Surgical Safety Checklist made its debut in December 2008 than the IHI Open School for Health Professions chapter leaders were knocking on the doors of academic deans and hospital leaders looking for institutions willing to help create a culture of safety and adopt the checklist. It is understandable that we should want to execute hospital processes to better serve patients when evidence is so resounding. Why shouldn't there be an ICU walker-like solution for every kind of process?

A quote by Margaret Mead is immortalized on the wall of our office just above my desk. It reads, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." ▲

For more information on the WHO Surgical Safety Checklist, visit www.ihio.org and click on the WHO Surgical Safety Checklist link. Find out more about the IHI Open School for Health Professions at www.ihio.org.

This column is written by the Institute for Healthcare Improvement. Eva Luo, special assistant to Donald Berwick, MD, can be reached at eluo@ihio.org. She will be attending the University of Michigan Medical School in the fall.



Joseph S. Bujak, MD, FACP

No Ordinary Employees

How to align physician and organizational interest for solid success.

Healthcare organizations (HCOs) are employing physicians at an ever accelerating rate. For both parties, this means new opportunities and unique challenges. Achieving success in this rapidly changing terrain demands that healthcare executives understand the forces shaping the trend, clearly define their needs and expectations and grasp the subtle differences that influence physician motivation. Only then can leaders and physicians work together to build win-win systems that align everyone's goals.

The simple fact is this: Traditional private-practice, fee-for-service, allopathic medicine is becoming unsustainable. But while the fact is simple, the forces transforming the provider community are quite complex.

Specialization—Physicians are becoming progressively more specialized. I used to know what orthopedists did. Now they subspecialize and restrict their practice to operating on hands, backs, specific joints, etc. Do you want a back surgeon to repair your broken leg? In a similar manner, cardiologists specializing in electrophysiology “don't do chest pain.”

Technology—There is a growing demand for access to new

technology, which will continue to intensify as the baby boom generation ages. Boomers want to stay forever young and active. Indeed, they seem to believe that death is an optional event.

Organizations without a vision of what they want to create will default to expediency, employing anyone and everyone who shows up until the money runs out.

More Work/Less Money—As overhead increases and reimbursement fails to keep up, shrinking margins drive physicians to generate progressively more units of production. Payors and regulators increasingly demand transparency and public reporting of data, which is reinforced by pay-for-performance initiatives. Recovery audit contractors are auditing physician billing practices, further complicating the business side of medicine. All of this data collection and reporting further increases the need for expensive information technology systems. Keeping track of the formulary restrictions of

different insurance carriers is an absolute nightmare. For physicians, “This isn't what I signed up for” is becoming a common refrain.

Massive Reimbursement Shifts—Fewer people are covered by employer-based private insurance, and the percentage of patients covered by government programs is progressively increasing. As the costs for healthcare services rise, more and more people find healthcare unaffordable. As physicians in private practice refuse to accept Medicare and Medicaid patients, accessing physicians becomes difficult.

Paradigm Shift

Today's physicians leave training focused almost exclusively on finding employment. Established practices are finding it difficult to recruit new physicians and sustain their practices. As profit margins continue to shrink, exhausted physicians are unable to generate more units of service. More than ever, time is money, so physicians are giving less time to nonrevenue-generating pursuits: Where they historically engaged in peer review and other medical staff activities gratis, they now seek reimbursement. The growing trend to pay physicians for taking emergency calls is significantly stressing the hospital's operating margin.

This column is made possible in part by Trane.



Meanwhile, newly trained physicians find themselves in a seller's market, increasingly able to demand a guaranteed high income with additional perks such as loan repayment assistance, relocation allowances, income guarantees, limited working hours and even employment for their spouses. This angers older physicians in private practice who, with rising overhead, have to generate more gross revenue just to achieve an equivalent net income. Hospitals have to recruit physicians to continue to provide necessary services, pitting them in

competition with established physicians and, in these physicians' eyes, devaluing their years of service and historical loyalties.

Recently the federal government has significantly reduced payment for Medicare-related ancillary services that are provided in physician-owned facilities. Medicare also has initiated a demonstration project around bundled pricing. All of these dynamics mean physicians can make more money with less stress as employees. Once this was

true mainly for primary care physicians; now it applies to higher-end specialties as well.

HCOs are changing to meet this new reality. They are employing physicians as intensivists, hospitalists and laborists. They are hiring trauma surgeons rather than paying physicians for ER calls. They are continuing preferred contracting relationships with physician groups to provide imaging, emergency, laboratory and anesthesiology services. They

Six Things You Must Know Before Hiring Physicians

- 1. Know what you're building.** What are you building? The answer to this question will define your organizational purpose: Why do we exist? Why should anyone want to seek our services? What distinguishes us from other healthcare organizations? What is the source of our pride? Are we building a multispecialty group practice or a single specialty practice? Will we provide wholesale or retail services? Those you recruit must be compatible with what you are trying to build.
- 2. Know why you're building.** As D.M. Malone explains in his book, *Small Unit Leadership: A Commonsense Approach*, it is important to appreciate how the elements of skill, will and teamwork forge successful relationships and build organizational pride. Respecting the skills of others is essential for building trust and pride. Aligning self-interest with group interest takes an act of will. Teamwork only happens when individuals believe they can achieve more of what they care most about by working together rather than alone.
- 3. Know your value hierarchy.** It is important to know not only what you value but the order in which your values fall. When faced with circumstances that force you to choose among values, which takes precedence? It is this value hierarchy that guides decision making. It defines who you are, what you stand for and what you won't stand for. Know what is nonnegotiable.
- 4. Know how you define success.** Know and articulate the metrics you will employ and how those measurements will gauge and guide your organization into the future. How will you know that you are making progress? What are the measurable outcomes that provide reinforcing feedback or call for a course correction?
- 5. Know who's in charge.** Is employing physicians a core competency? If not, where do you find that resource? Will it be a separate business or a subsidiary of your existing business? Is your willingness to employ physicians strategic and creative or reactive and defensive?
- 6. Know how you will pay.** How should the physicians be reimbursed? You get the behaviors you reward and you eliminate what you do not. Can you create a business model that is a vehicle for your shared purpose?

increasingly are taking a service-line orientation and hiring physicians to manage these lines' clinical components.

This paradigm shift demands careful attention to integrating physician and HCO mission, goals, work styles and culture. Before setting off on a physician hiring spree, healthcare leaders must be able to determine and clearly articulate their philosophy and strategy in this area, or they may risk alienating physicians before they even get started. (See "Six Things You Must Know Before Hiring Physicians" on page 79.) Key among the components of success is an understanding of what motivates physicians.

The Expert Culture

Physicians comprise what sociologists label an expert culture, meaning they are driven by their own vision and self-interest, not an organization's mission. The alignment of physicians is critically dependent on presenting an inspiring vision that ties the organization's interest to their own.

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This paradigm shift demands careful attention to integrating physician and HCO mission, goals, work styles and culture. Before setting off on a physician hiring spree, healthcare leaders must be able to determine and clearly articulate their philosophy and strategy in this area, or they may risk alienating physicians before they even get started.

Aligning with physicians can begin with engaging them in dialogue. A leader who is an attentive listener and suspends judgment while engaged in meaningful conversation with others lays the foundation for effective communication and trust building. Individuals must be able to connect the dots themselves, create new understandings and generate their own "ah-hahs."

Physicians are challenging employees. You cannot view them as you view others who are paid by the organization. In your relationship

with physicians you must be a servant leader. In order to fully engage physicians in the workplace it is essential to give them respect and a sense of control. They must be given authorship for their work. Finally, it is critical that the organizational vision be about more than money. People must connect their sense of purpose to their work. That is how you access their discretionary effort, create a sense of commitment and generate loyalty.

Organizations without a vision of what they want to create will default to expediency, employing anyone and everyone who shows up until the money runs out. To try and retrofit this unselected group of individuals into a team will be impossible.

When economic security is the sole motivator for seeking employment, the enterprise degenerates into a zero-sum game of economic self-interest. But when those who join together do so because they desire the same outcomes, they create a sense of shared purpose and a willingness to suppress individual self-interest in deference to the common good. It is this vision that will lead to success for all involved. ▲

Joseph S. Bujak, MD, FACP, is vice president of medical affairs for Kootenai Medical Center, Coeur D'Alene, Idaho. Dr. Bujak can be reached at jbujak@attglobal.net. He is also author of Inside the Physician Mind: Finding Common Ground with Doctors, published by Health Administration Press. For more information visit the Books & Journals area of ache.org.

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LEADERSHIP

Eight-Point Executive To-do List

As an executive, how you handle your fear and stress sends ripple effects throughout your organization. Below are steps you can take to keep you on an even keel.

1. Macro manage and under steer. This approach empowers employees and lessens their anxiety.
2. Increase communication. You can encourage positive storytelling and prevent rumors among employees about the organization's leadership.
3. Be approachable. You will increase the chance that direct reports will provide ideas and feedback without fear.
4. Use strategic thinking that is centered on the big picture. This leaves people with good direction, a positive attitude and faith that you have the

department/organization moving in the right direction.

5. Provide resources so employees have the tools and capacity to serve their patients.
6. Keep things professional. This causes employees to take action instead of placing blame.
7. Be encouraging. Faultfinding only generates more blame, paranoia and political gamesmanship.
8. Take care of yourself with a proper diet, sleep and exercise.

Following are two "mini-case studies" that illustrate the value of some of the steps above:

Fred micromanaged because he was afraid he gave his employees bigger goals/tasks than they could handle. He was afraid they would fail, so he supervised their every move. When he realized that his fear was internal and ungrounded, he addressed his managerial competence in a forthright manner. He worked with his employees to plan and organize the new project instead of telling them what to do.

Mary blamed her co-workers for the problems and breakdowns they experienced in her department. Upon reflection, she realized she was afraid of being blamed by her boss, and she unwittingly spread her fear, thereby causing more problems and breakdowns. She realized that, instead, by making clear requests of her people and helping them organize their work projects, she could let go of worrying about failure and spend time supporting her team.

Source: Adapted from an article by Michael O'Brien, EdD, president, the O'Brien Group, Cincinnati. Visit www.obriengroup.us.

ORGANIZATIONAL IMPROVEMENT

Are You in Technology Overload?

Technology has provided revolutionary devices during the past few years that have allowed us to perform many tasks once thought impossible. Unfortunately, too many people are overdosing on e-mails, Blackberries and online activities. Fortunately, you can control how technology participates in your life. The following suggestions can help.

Evaluate the time you are "connected"

E-mailing during off-hours is OK. The problem, however, comes when you work a full eight-hour day, plus stay up into the wee hours of the night e-mailing. This is when you need to evaluate your "on" time.

Document the amount of time you're connected each day. Is your cell phone always on? Are you regularly on the computer until midnight? Do you check your messages while you are playing with the kids? Is your e-mail program always running in

the background? Do you feel panicked when you are unplugged? If the answer to these questions is yes, then you should figure out why you are connected at certain times and why you can't turn the device or program off.

List how technology tools should ease your life

Technology can be your friend, if you use it within boundaries and limits, and for the reason it was intended. Get back to the basics of why you need technology. Most likely, you wanted tools such as e-mail and your cell phone to be a convenience, not a burden. Map out how you can best use technology in a way that is convenient for you.

Stop blaming technology

If you believe you can't get away from the constant ringing of your cell phone or the nonstop barrage of e-mail messages, maybe it is time to take some responsibility

for your situation. If you can't turn your cell phone off for an hour (or disable your e-mail for a half-day), what does that say about the way you manage your life? Remember, someone has to push the "on" button.

Get serious about time management

How do you spend your time? Instead of allowing incoming e-mail messages to always pop up on your screen, check your e-mail twice per day and schedule a certain amount of time for each e-mail session. If you allow your incoming office calls to go to voicemail, why can't you turn off your cell phone for certain hours of the day and let those calls go to voicemail? Schedule your technology-related items and priorities just as you would any other task on your to-do list. Make a schedule that includes time for everything—work and personal activities—and then stick to it.

Source: Adapted from an article by Carol Ring, vice president, Strategic Initiatives, Rogers Cable. Visit www.carolring.ca.

COMMUNICATION

Rally Your Employees Through Words

The economy is not in the best shape. Maybe you have noticed. Your employees certainly have. But what is a leader to do?

There is no easy answer, quick fix or one solution. But leaders at every level—from CEOs to line managers—can do something to address their employees' worries and to rekindle their motivation. They can give a speech.

A speech in difficult times can be anything from a formal companywide address to casual remarks at the start of a new shift. But the intent is always the same: to keep employees focused, motivated and working hard.

To make your speech more motivating, follow these guidelines:

Lead with and interpret the facts

Be as open, honest and forthcoming as possible. Give a complete account of the situation as objectively as you can. If you hold anything back or if you are evasive, you will feed your employees' fear and compromise your credibility. It is your responsibility as a leader to gather all the facts, evaluate them, analyze them and come to some understanding of what they mean. And then it is your responsibility to share your understanding with your employees. Just don't tell them, for example, revenue has declined 30 percent; tell them what a 30 percent drop in revenue means. Help them understand what is going on.

Acknowledge people's feelings

You don't want to turn your speech into a therapy session. But if you ignore your employees' feelings, they will think you're out of touch, or worse, that you don't care.

Acknowledge their feelings in a general way, using broadly applicable words like *difficulties*, *worries*, *concerns*, *anxieties* or *fears*. Acknowledge what people are feeling and move on.

Be action oriented

It's counterproductive at best to say, "You're wrong to think like that" or "You shouldn't feel that way." You can't change how people think or feel, but you can change how they act. And by changing how they act, you create the possibility that they will change their thoughts and feelings.

Say what you want and explain why they want it too

Tell your employees in a short, simple sentence exactly what you want them to do. Then show them how doing what you want will help them achieve what they want. If you want them to work longer or harder or in a different way, you have to figure out how they will benefit from doing so. What's in it for them?

"Be the change you wish to see"

The words of Gandhi are as true today in the work world as they were 50 years ago in India. Your employees don't simply listen to your words. They filter everything you say through their experience of you. Your actions, attitude and interactions with them are more than an example for them to follow; they also are the lasting message people will take away from your talk.

If the challenge of giving such a speech seems overwhelming, consider this: Your employees want you to succeed. They don't want to slog through their days, depressed and anxious. They want you to help them keep hope alive.

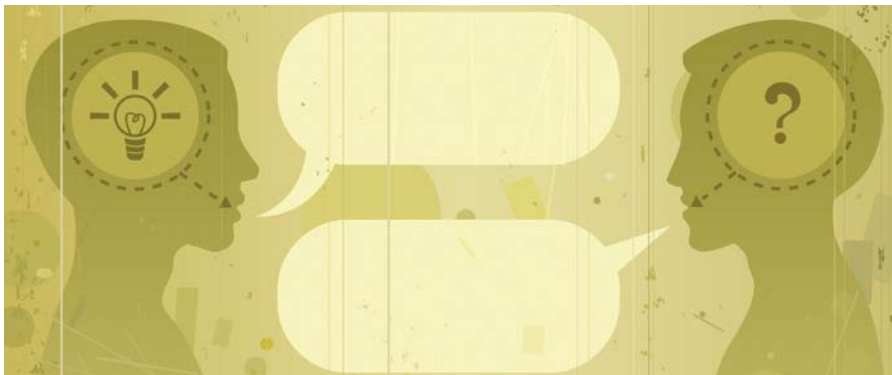
"If we cannot end now our differences, at least we can help make the world safe for diversity."

—John F. Kennedy

Submit a Pointer to "Professional Pointers"

Have you implemented workplace strategies that could help your colleagues succeed as well? *Healthcare Executive* invites you to share the workplace knowledge that has played a role in your career success.

To submit an item for consideration, please send it via e-mail to "Professional Pointers" at he-editor@ache.org. You also may fax it to (312) 424-9390.



Source: Adapted from an article by Chris Witt, an executive speech coach and founder of Witt Communications. Visit www.wittcom.com.

This column is made possible in part by GE Healthcare.

GE Healthcare



ACHE Is Now Accepting Nominations For...

Gold Medal Award

The Gold Medal Award is the highest honor bestowed by the American College of Healthcare Executives on outstanding leaders who have made significant contributions to the healthcare profession. The purpose of this award is to identify ACHE Fellows who best exemplify leadership at the organizational, local, state/provincial and national levels and who continually contribute to the improvement of the delivery of healthcare services and community health.

A maximum of two Gold Medal Awards may be awarded each year: one to an outstanding executive in a healthcare delivery organization, and the second to an executive in a non-delivery healthcare organization (alliances, associations, universities, consulting firms, etc.).

Criteria—The Candidate Must:

- Be a Fellow of the American College of Healthcare Executives
- Have demonstrated active leadership in the American College of Healthcare Executives
- Have demonstrated achievement in one or more of the following areas:
 - Leadership and executive performance
 - Health services/patient care delivery
 - Professional development
 - Management and organizational development
 - Health services activities
- Be present at ACHE's 2010 Congress on Healthcare Leadership to receive the commendation

Nomination Process

Your Nomination Should Include:

- A nomination letter (not to exceed three pages) that highlights the characteristics listed under "Criteria." The letter should include a brief summary of:
 - The candidate's involvement in local, state/provincial, regional and national healthcare and community service organizations
 - Published articles, books and professional papers the candidate has written
 - Special commendations, awards or honors that have been granted by civic, military, fraternal or service organizations or any other extraordinary awards or honors
- The candidate's curriculum vitae
- Three letters of support (not to exceed two pages each), including no more than one letter from the candidate's employing organization

Please submit all information together in one packet.

Deadline for nomination packet: August 20, 2009



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Robert S. Hudgens Memorial Award

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

Lifetime Service Award

The Lifetime Service Award was created to recognize Life Fellows and Retired Fellows who have made significant contributions to the American College of Healthcare Executives.

Note: Because the Gold Medal Award and Lifetime Service Award criteria overlap, Gold Medal Award winners are not eligible for the Lifetime Service Award.

Mail your nomination for receipt by the deadline noted to:

Gerard J. Berish, CAE
Regional Director
Division of Regional Services
American College of Healthcare Executives
1 N. Franklin St., Ste. 1700
Chicago, IL 60606-3529

Criteria—The Candidate Must:

- Have a minimum of a graduate degree from an accredited university or college
- Be a Fellow of the American College of Healthcare Executives
- Have not reached his/her 40th birthday by March 31, 2010
- Hold a CEO or COO position in a healthcare organization
- Be present at ACHE's 2010 Congress on Healthcare Leadership to receive the commendation

Nomination Process

Your Nomination Should Include:

- A letter stating the name and address of the nominator and nominee—*no other information is required*

The nominee will receive notice of the nomination, along with a request to complete and return a personal data form.

Deadline for nomination letter: July 17, 2009

Criteria—The Candidate Must:

- Be a Life Fellow or Retired Fellow of the American College of Healthcare Executives
- Have contributed to ACHE in one or more of the following manners:
 - Held elected office (Chairman, Governor and/or Regent)
 - Served as a member of a Regent's Advisory Council
 - Served on ACHE committees or task forces
 - Participated in ACHE activities such as educational offerings
 - Participated in an ACHE independent chapter, officially designated local healthcare executive group or women's healthcare executive network
- Be present at ACHE's 2010 Congress on Healthcare Leadership to receive the commendation

Nomination Process

Your Nomination Should Include:

- A letter stating the name and address of the nominator and nominee—*no other information is required*

The nominee will receive notice of the nomination, along with a request to complete and return a personal data form.

Deadline for nomination letter: July 17, 2009

If you have any questions about the awards, contact Gerard J. Berish, CAE, in the Division of Regional Services at (312) 424-9323 or via e-mail at gberish@ache.org.



ACHE Affiliate Update

Evans Installed as 2009–2010
ACHE Chairman

Evans

Charles R. Evans, FACHE, president and CEO, International Health Services Group (IHSG), Alpharetta, Ga., assumed the office of Chairman of the

American College of Healthcare Executives at the March 21 Council of Regents meeting preceding the 2009 Congress on Healthcare Leadership in Chicago. He received the gavel from MG David A. Rubenstein, FACHE, of the U.S. Army, outgoing ACHE Chairman.

As Chairman, Evans will serve the second part of a three-year term in ACHE's consecutive chairmanship offices: Chairman-Elect, Chairman and Immediate Past Chairman. Before being named Chairman-Elect, Evans served as an ACHE Governor from 2004 to 2007.

Evans has been president and CEO of IHSG since 2007. He founded the social enterprise to support health services development in underserved areas of the world. Before his current position, Evans served as president—Eastern Group of Nashville, Tenn.-based Hospital Corporation of America (HCA). Prior to joining HCA, he served in executive roles at Memorial Medical Center in Jacksonville, Fla., and Community Hospitals in Indianapolis.

He serves on numerous boards, including West Virginia Wesleyan

College, CSA Health System and MedShare International. In addition, he has served on state hospital association boards in Georgia, Tennessee and Florida. Evans also is clinical assistant professor of Family and Preventive Medicine at Emory University School of Medicine and holds an appointment as an adjunct faculty member at West Virginia Wesleyan College.

Board certified in healthcare management as an ACHE Fellow, Evans received his MBA from Indiana University School of Business, a master of arts degree from Indiana University of Pennsylvania and his bachelor's degree from West Virginia Wesleyan College.

Van Gorder Installed as 2009–2010
Chairman-Elect

Van Gorder

Christopher D. Van Gorder, FACHE, president and CEO, Scripps Health, San Diego, has been elected Chairman-Elect of ACHE. Board certified in healthcare management as an ACHE Fellow, Van Gorder previously served as an ACHE Governor since 2006. He has been president and CEO of Scripps Health since 2000.

In addition to his work with ACHE, Van Gorder serves as a commissioner on the California Emergency Services Commission, as a second term commissioner for the United States National

Commission for UNESCO and as editorial board member for The Governance Institute and is on the board of directors of the San Diego Regional Economic Development Corp. He is a clinical professor in health administration at the University of Southern California, where he also serves on the Healthcare Administration Advisory Board of the university's School of Policy, Planning and Development. In addition, he is a reserve commander in the San Diego County Sheriff's Department Search and Rescue Unit and a licensed emergency medical technician.

Prior to joining Scripps Health, Van Gorder served in executive roles at Memorial Health Services in Long Beach, Calif., Long Beach (Calif.) Memorial Medical Center and Anaheim (Calif.) Memorial Medical Center. He received his master's degree in public administration/health services administration from the University of Southern California and completed the Wharton System CEO Program at the University of Pennsylvania. Van Gorder earned his bachelor's degree from California State University, Los Angeles.

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This column is made possible in part by
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Autry, Garfunkel, Lynch and Smalley
Elected ACHE Governors



Autry

Paula R. Autry, FACHE, president, Mount Carmel East Hospital, Columbus, Ohio, has been elected to serve a three-year term on ACHE's Board of Governors.

Autry was named president at Mount Carmel East Hospital, a 399-bed, acute-care hospital, in 2007. Prior to this, she served as executive vice president/administrator of Bon Secours Richmond (Va.) Community Hospital from 2002 to 2007. She also served Erlanger Health System, Chattanooga, Tenn., as senior vice president from 1995 to 2002 and served the University of South Alabama Medical Center, Mobile, as assistant administrator from 1987 to 1995.

Before being elected an ACHE Governor, Autry was the Regent-at-Large for District 2 from 2006 through 2007 and Regent-at-Large for District 3 from 2004 through 2005. In addition to her service to ACHE, Autry serves on the board of directors of Taylor Station Family Health and Medigold, a Medicare Advantage program. She has previously served on the board of directors of the Richmond Community Hospital Foundation and Girls Inc. In 2008, she was named to Who's Who of Black Columbus. She also is a member of the National Association of Health Services Executives and the United Way Key Club and a former member of CHIP of Virginia and the

Chattanooga Chamber of Commerce.

Board certified in healthcare management as an ACHE Fellow, Autry received her master's degrees in business administration and health administration from Tulane University and her bachelor's degree from the University of Notre Dame.



Garfunkel

Sanford M. Garfunkel, FACHE, network director for the VA Capitol Health Care Network with the Department of Veterans Affairs, Linthicum Heights, Md., has been elected to serve a three-year term on ACHE's Board of Governors.

Garfunkel has served as network director for the VA Capitol Health Care Network since April 2007. Prior to this, he served as director of the Washington, D.C., VA Medical Center for 12 years. He also served in leadership positions in VA medical centers in Manhattan, Bronx and Brooklyn, N.Y., and East Orange, N.J., as well as VA Central Office, Washington, D.C.

Before being elected an ACHE Governor, Garfunkel was appointed to the Board of Governors as an interim Governor in 2008. Previously, he was the Department of Veterans Affairs ACHE liaison from 1993 through 2003. In addition to his service to ACHE, Garfunkel has served on the board of directors of the District of Columbia Hospital

Association and the Senior Executives Association.

Board certified in healthcare management as an ACHE Fellow, Garfunkel received his master's degree in healthcare administration from the Baruch College and the Mt. Sinai School of Medicine, City University of New York, and his undergraduate degree from Baruch College, City College of New York.



Lynch

John J. Lynch III, FACHE, president/CEO, Main Line Health System, Bryn Mawr, Pa., has been elected to serve a three-year term on ACHE's Board of Governors.

In 2005, Lynch was named president/CEO at Main Line Health System, a multifaceted integrated healthcare delivery system that employs approximately 10,300 people, and has 2,100 volunteers and an affiliated medical staff of approximately 1,900 physicians, dentists and podiatrists. Prior to this, Lynch was the executive vice president/system COO for St. Luke's Episcopal Health System, Houston, from 2003 to 2005. He also served St. Luke's as executive vice president/hospital CEO from 2000 to 2005. Prior to this position, he held a variety of other positions at St. Luke's.

Before being elected an ACHE Governor, Lynch was the ACHE Regent for Texas—Southeast from 2001 to 2005. In addition to his service to ACHE, he has served as a member of the board of the

American Hospital Association, the Texas Hospital Association, and the Greater Houston Hospital Service Corporation, and chair of the Hospice at the Texas Medical Center. He is currently a member of the boards of the American Heart Association and the United Way of Southeastern Pennsylvania.

Board certified in healthcare management as an ACHE Fellow, Lynch received his master's degree in health administration from Washington University School of Medicine and his bachelor's degree from the University of Scranton.



Smalley

Diana L. Smalley, FACHE, president/CEO, Mercy Health System of Oklahoma, Oklahoma City, has been elected to serve a three-year term on ACHE's Board of Governors.

Smalley was named president/CEO at Mercy Health System of Oklahoma in 2007. Prior to her current position, Smalley served Avantas LLC, Omaha, Neb., as president from 2005 to 2007. At Alegent Health, Omaha, Neb., her roles included senior executive from 2003 to 2005, vice president for operations from 1999 to 2003 and COO from 1997 to 1999. She also served Avantas LLC as co-founder/managing representative from 1999 to 2004. Her previous roles include Midlands Community Hospital, Papillion, Neb., as CEO from 1995 to 1997, COO from 1983 to 1995 and director of nursing from 1978 to 1983;

and Springfield (Ill.) Community Hospital as its director of professional relations from 1976 to 1978.

Before being elected an ACHE Governor, Smalley was the Regent for Nebraska from 2002 through 2006. In addition to her service to ACHE, Smalley has been a member of the board of directors of Memorial Community Hospital, the Nebraska Stroke Foundation and the Nebraska Board of Ambulance Advisors, serving as its chair. She is currently on the board of directors for the Oklahoma State Chamber of Commerce and the United Way of Greater Oklahoma City.

Board certified in healthcare management as an ACHE Fellow, Smalley received her master's degree in public health from the University of Minnesota and her bachelor's degree from Midland Lutheran College.

ACHE Welcomes New Regents

Twenty-four healthcare executives have been elected to serve three-year terms as Regents for ACHE and will represent the affiliates in their respective jurisdictions. The Regents took office on Saturday, March 21, at the Council of Regents Meeting in Chicago. In addition, Regents were recently appointed to represent affiliates on an interim basis for Army, Kentucky, New Mexico, Vermont and Wyoming. ACHE welcomes:



Anderson



Calvin-Casey



Gilmore



Wooldridge



Jones

Alabama (District 4)

William H. Anderson, FACHE, president/CEO, Colbert County—Northwest Alabama Health Care Authority/Helen Keller Hospital, Sheffield

Alaska (District 5)

Michelle E. Calvin-Casey, FACHE, community relations director, Bartlett Regional Hospital, Juneau

Arkansas (District 4)

Phillip K. Gilmore, FACHE, president, Gilmore & Associates Consulting LLC, Malvern

Army (District 6)

LTC Stephen C. Wooldridge, PhD, FACHE, Iraq (Interim Regent)

Delaware (District 1)

Lynn C. Jones, FACHE, president, Christiana Care Home Health & Community Services Inc., New Castle



Machen



Wimby



Roberts



Johnson



Jolly



Prussian



Kishner



Beloff



Fosdick



Legere



Gershon



Krowinski

**Georgia—Coastal Plains
(District 2)**

Stephen J. Machen, FACHE, chief executive officer/senior vice president, Sumter Regional Hospital East, Americus

**Georgia—Piedmont Plateau
(District 2)**

Toni F. Wimby, FACHE, associate administrator, Emory Hospitals, Emory Healthcare, Atlanta

**Hawaii/Pacific
(District 5)**

Kevin A. Roberts, FACHE, president/CEO, Castle Medical Center, Kailua

**Idaho
(District 5)**

Wade C. Johnson, FACHE, president/CEO, Weiser Memorial Hospital

**Kansas
(District 4)**

Jay P. Jolly, FACHE, chief executive officer, Goodland Regional Medical Center

**Kentucky
(District 3)**

Mark M. Prussian, FACHE, chief executive officer, The Eye Care Institute, Louisville (Interim Regent)

**Louisiana
(District 4)**

Janice L. Kishner, RN, FACHE, COO/chief nursing executive, East Jefferson General Hospital, Metairie

**Massachusetts
(District 1)**

Andrea Beloff, FACHE, senior administrative director, Radiation Oncology, Massachusetts General Hospital, Boston

**Nebraska
(District 3)**

Glenn A. Fosdick, FACHE, president/CEO, The Nebraska Medical Center, Omaha

**New Hampshire
(District 1)**

Tina Legere, FACHE, vice president, operations/chief quality officer, Catholic Medical Center, Manchester

**New Mexico
(District 4)**

Howard J. Gershon, FACHE, principal, New Heights Group, Santa Fe (Interim Regent)

**New York—Empire Area
(District 1)**

Rochelle L. Krowinski, RN, FACHE, chief operation officer, Clinical Operation and Regional Affiliations, Roswell Park Cancer Institute, Buffalo



Grocholski



Jaspersen



Ruberte



Cordeiro



Scott



Coppola



Marano



Tipple



Molitor



Kawwass



Rivera



Faubion

**Oklahoma
(District 4)**

James F. Grocholski, FACHE, chief executive officer, Memorial Hospital of Texas County, Guymon

**Oregon
(District 5)**

Steven W. Jaspersen, FACHE, chief executive officer, Good Samaritan Regional Medical Center, Corvallis

**Puerto Rico
(District 2)**

Henry Ruberte, FACHE, president, HR Healthcare Management & Consulting, Trujillo Alto

**Rhode Island
(District 1)**

August B. Cordeiro, FACHE, vice president, Professional Services, chief administrative officer, Rhode Island Hospital/Lifespan, Providence

**Tennessee
(District 4)**

Vanda L. Scott, EdD, FACHE, chief executive officer, Select Specialty Hospitals, Knoxville

**Texas—West
(District 4)**

M. Nicholas Coppola, PhD, FACHE, program director and associate professor, MS-Clinical Practice Management, Texas Tech University Health Sciences Center, Lubbock

**Vermont
(District 1)**

Angeline M. Marano, FACHE, chief operating officer, Fletcher Allen Health Care, Burlington (Interim Regent)

**Virginia
(District 2)**

Cynda M. Tipple, FACHE, chief operating officer, Prince William Hospital, Manassas

**Wyoming
(District 5)**

Margie R. Molitor, FACHE, chief executive officer, Banner Health Washakie Medical Center, Worland (Interim Regent)

Regent-at-Large for District 2

Bassam A. Kawwass, FACHE, chief executive officer, The Muasher Center for Fertility and IVF, Fairfax, Va.

Regent-at-Large for District 4

Maria C. Rivera, FACHE, chief executive officer, Savoy Medical Center, Mamou, La.

Regent-at-Large for District 5

John G. Faubion, FACHE, president, Faubion Associates Executive Search, Glendale, Calif.

ACHE's 12th Corporate Forum a Success

More than 45 individuals representing ACHE's 2009 Corporate Partners gathered at the Corporate Forum in Chicago, January 14–15, 2009. ACHE's current Immediate Past Chairman MG David A. Rubenstein, FACHE, Deputy Surgeon General, U.S. Army, welcomed the attendees.

John H. Ferman, the featured speaker, presented "Funding and Reimbursement Challenges of Healthcare Providers." Ferman is principal for Health Policy Alternatives Inc. in Washington, D.C.

The presentation included panel discussions with Bruce M. Elegant, FACHE, president/CEO of Rush Oak Park Hospital in Oak Park, Ill.; Lindsay K. Mann, FACHE, chief executive officer of Kaweah Delta Health Care District in Visalia, Calif.; and Kevin L. Unger, FACHE, president/CEO of Poudre Valley Hospital in Fort Collins, Colo.

The following ACHE 2009 Premier Corporate Partners were invited to participate in this event: AmerisourceBergen Corporation; ARAMARK Healthcare; Cardinal Health; Eclipsys Corporation; GE Healthcare; HCA; Johnson Controls, Inc.; Ortho-McNeil; Philips Healthcare; sanofi-aventis U.S.; Siemens Healthcare; and Trane.

ACHE Call for Nominations for the 2010 Slate

ACHE's 2009–2010 Nominating Committee is calling for applications for service beginning in 2010. All affiliates are encouraged to participate in the nominating process. ACHE Fellows are eligible for any of the Governor and Chairman-Elect vacancies and are eligible for the Nominating Committee and

Regent-at-Large vacancies within their district. Open positions on the slate include:

- Nominating Committee Member, District 1 (two-year term ending in 2012)
- Nominating Committee Member, District 4 (two-year term ending in 2012)
- Nominating Committee Member, District 5 (two-year term ending in 2012)
- Regent-at-Large, District 3 (three-year term ending in 2013)
- Governor (three-year term ending in 2013)
- Governor (three-year term ending in 2013)
- Governor (three-year term ending in 2013)
- Governor (three-year term ending in 2013)
- Chairman-Elect

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

- District 1: Canada, Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont
- District 3: Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin
- District 4: Alabama, Arkansas, Kansas, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee and Texas
- District 5: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming

Candidates for Chairman-Elect and Governor should submit an application to serve, a copy of their resume and up to 10 letters of support. Candidates for Regent-

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

Applications to serve and self-nominations can be submitted by U.S. mail and postmarked between Jan. 1 and July 15. Mail applications to serve to: Alyson Pitman Giles, FACHE, chairman, Nominating Committee, c/o Julie Nolan, American College of Healthcare Executives, 1 N. Franklin St., Ste. 1700, Chicago, IL 60606-3529. Materials also can be sent via e-mail to jnolan@ache.org or faxed to (312) 424-2828 by the July 15 deadline.

The first meeting of ACHE's 2009–2010 Nominating Committee was held on Tuesday, March 24, 2009, during the Congress on Healthcare Leadership in Chicago. During the meeting an orientation session was conducted for potential candidates, giving them the opportunity to ask questions regarding the nominating process. Immediately following the orientation, an open forum was provided for ACHE affiliates to present and discuss their views of ACHE leadership needs.

Following the July 15 submission deadline, the committee will meet to determine which candidates for Chairman-Elect and Governor will be interviewed in person on Oct. 29, 2009. All candidates will be notified in writing of the committee's decision by Sept. 30, 2009.

To review the Candidate Guidelines, visit the Affiliates Only area of ache.org and select the "Candidate Guidelines" link on the left-hand side of the page. If you have any questions, please contact Julie Nolan at (312) 424-9367 or jnolan@ache.org.

People

Affiliate-Led Hospitals Named to Fortune's 100 Best Companies List

Several affiliate-led organizations have been named to *Fortune* magazine's 2009 list of "100 Best Companies to Work For":

- Griffin Hospital, Derby, Conn., led by President/CEO **Patrick A. Charmel, FACHE**
- King's Daughters Medical Center,

Ashland, Ky., led by President/CEO **Fred L. Jackson, FACHE**

- Lehigh Valley Hospital and Health Network, Allentown, Pa., led by President/CEO **Elliot J. Sussman, MD**
- Methodist Hospital System, Dallas, led by President/CEO **Stephen L. Mansfield, PhD, FACHE**
- Northwest Community Hospital,

Arlington Heights, Ill., led by President/CEO **Bruce K.**

- Crowther, FACHE**
- OhioHealth, Columbus, led by President/CEO **David P. Blom**
- Scripps Health, San Diego, led by President/CEO **Christopher D. Van Gorder, FACHE**
- Southern Ohio Medical Center, Portsmouth, Ohio, led by President/CEO **Randal Arnett**

Leaders in Action

MG David A. Rubenstein, FACHE Immediate Past Chairman

Colorado Association of Healthcare Executives Chapter Meeting, Ft. Carson, Colo.

ACHE Corporate Forum, Chicago

Texas Hospital Association Annual Conference, Austin, Texas

Charles R. Evans, FACHE Chairman

ACHE—Rhode Island Chapter Meeting, Warwick, R.I.

Mid-America Healthcare Executive's Forum, O'Fallon, Ill.

New Jersey Hospital Association Meeting, Princeton, N.J.

ACHE Staff Update

ACHE Announces Staff Hires

Alicia M. Borsa to customer service representative, Division of Membership.

Megan K. Downey to senior web editor, Division of Communications and Marketing.

Lisa Freund to editor-in-chief, *Healthcare Executive*, and editorial manager, Division of Communications and Marketing.

Alan L. Larson to research assistant, Division of Research.

Darrin D. Townsend to customer service representative, Division of Membership.



In Memoriam

ACHE regrettably reports the following deaths of ACHE affiliates as reported by the Division of Membership:

Arden Jean Biggar
Houston, Texas

Peter R. Carruthers, FACHE
Oakville, Ontario, Canada

Alvin J. Conway, FACHE
Tarrytown, N.Y.

Joseph J. Doney Jr., FACHE
Bradenton, Fla.

Natalie Knowles
Tallahassee, Fla.

John N. Krogness
New Braunfels, Texas

Doyle R. Liles, FACHE
Dallas, Texas

Richard H. Peterson
Medina, Wash.

Barry Leonard Schiff, FACHE
Bellerose, N.Y.

Sr. Anne M. Twohig, FACHE
Monroe, La.

Philippa Watson, FACHE
Toronto, Canada

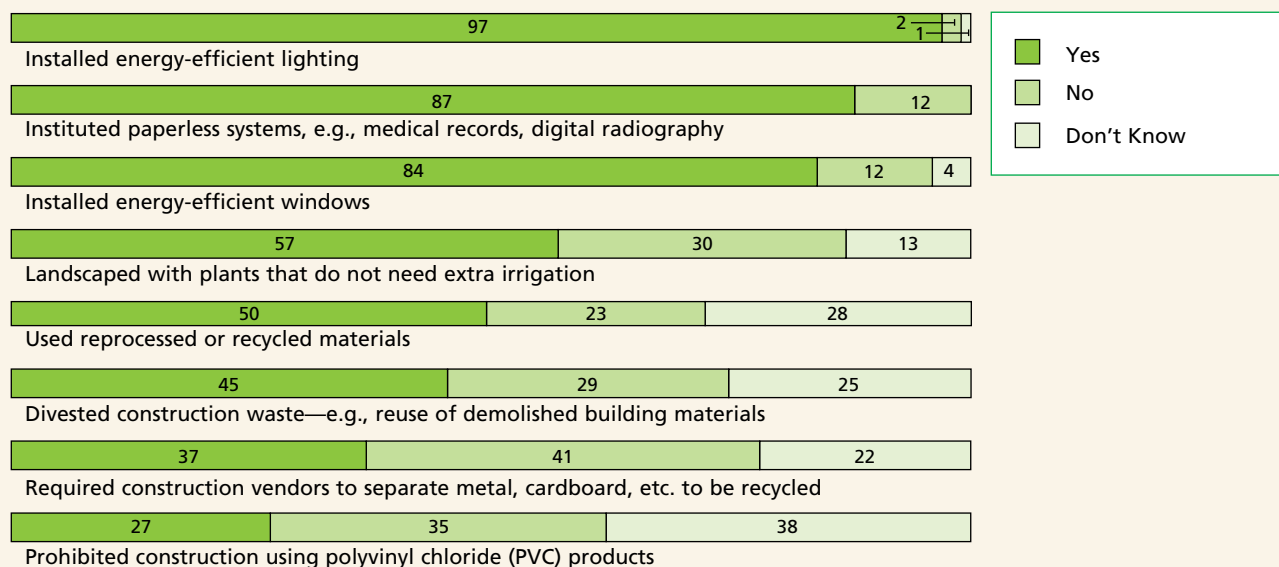


Going Green

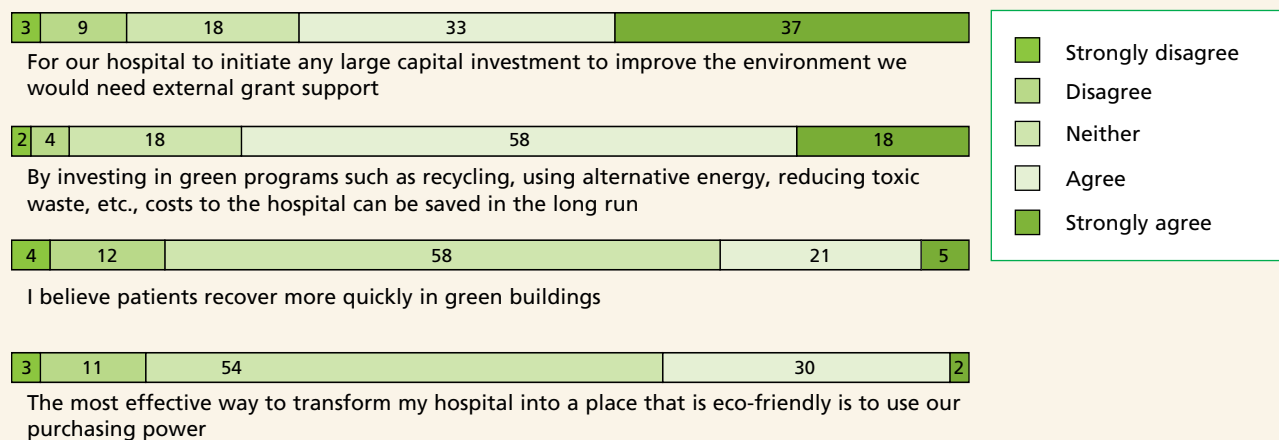
Results provided by ACHE's Division of Research

In January, ACHE's Division of Research conducted a study to learn what hospital CEOs are doing relative to implementing environmentally friendly initiatives. It distributed 970 surveys by fax to CEO affiliates, and 417 responses were received for a 43 percent response rate.

Sixty-five percent of survey respondents stated they had embarked on construction or major renovation projects since 2006. The construction projects incorporated green practices to a greater or lesser extent. The most common practice was to install energy-efficient lighting, which 97 percent of respondents stated their organizations had done.



When asked for their opinions on several green issues, CEOs agreed generally on two: that to initiate any large capital investment to improve the environment, they would need external grant support (70 percent agreed), and by investing in green programs such as recycling, using alternative energy, etc., costs savings could result in the long run (76 percent agreed). In general, CEOs recognize the long-run cost savings in going green but require a special infusion of funds for capital improvements.

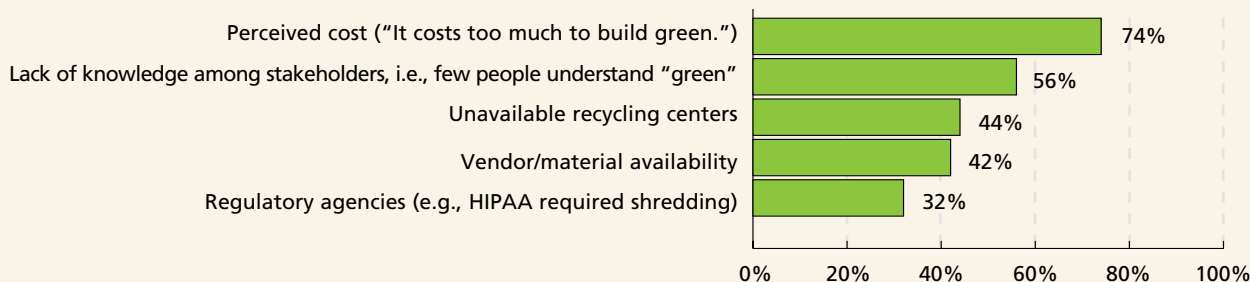




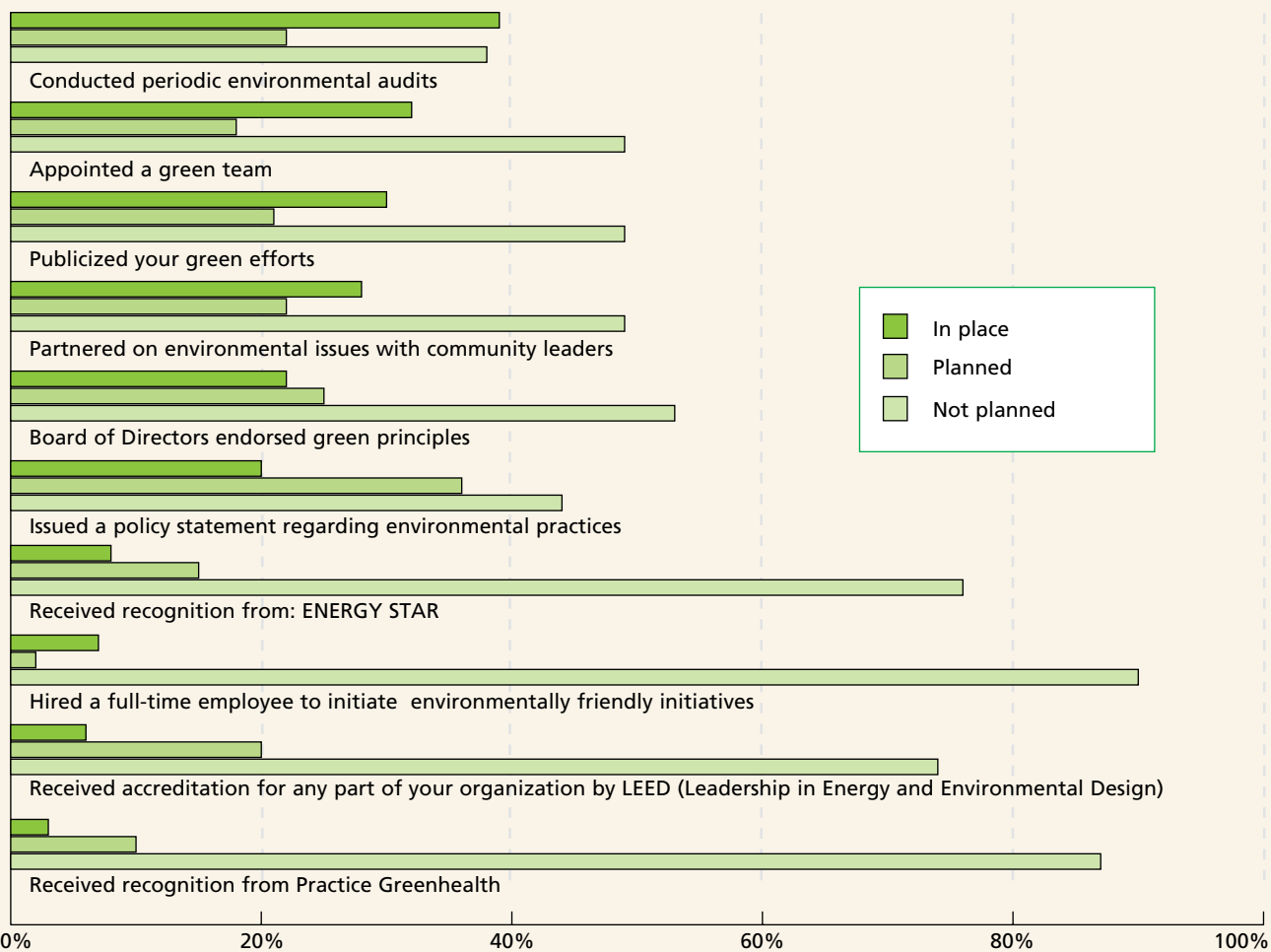
Going Green

Results provided by ACE's Division of Research

CEOs were asked to rate a list of barriers they faced when considering green initiatives. The graph below indicates the percentage of respondents who agreed the following were barriers. The most significant barrier, cited by 74 percent of respondents, was its perceived cost.



Survey findings suggest CEOs are beginning to initiate policies and practices to make their organizations environmentally friendly. For hospitals where green initiatives were not in place, many CEOs stated that these initiatives were planned.



Highlights from the ACHE meetings held in association with the 2009 Congress on Healthcare Leadership.

Regents Leadership Conference

Prior to the Council of Regents Meeting, Regents received various reports from ACHE staff, including updates on key strategic plan objectives. In addition, Frederick D. Hobby, president and CEO of the Institute for Diversity in Health Management (IFD), provided an overview of IFD's activities. The Regents then participated in concurrent strategy sessions on activating the power of volunteers, improving chapter performance, engaging hard-to-reach affiliates and reaching out to the Higher Education Network.

Council of Regents Meeting

Following are highlights from the ACHE Council of Regents Meeting, which was held in Chicago on Saturday, March 21, preceding the 2009 Congress on Healthcare Leadership.

ACHE Immediate Past Chairman Alyson Pitman Giles, FACHE, president and CEO, Catholic Medical Center, Manchester, N.H., presided over the meeting. After minutes from the March 8, 2008, Council of Regents Meeting were approved, MG David A. Rubenstein, FACHE, U.S. Army, summarized his year as Chairman and thanked his fellow Board members and the ACHE staff for their support and work during his tenure as Chairman.

The Council reviewed the 2008–2009 committee reports, approving those requiring action,

including the 2009 slate of candidates presented by the Nominating Committee. The nominee for Chairman-Elect, Christopher D. Van Gorder, FACHE, president and CEO of Scripps Health, San Diego, addressed the group. Van Gorder compared the challenges facing the healthcare management profession today—including the financial climate—to those encountered by ACHE's founders in 1933 and conveyed the continuing importance of ACHE's mission. He said ACHE's role in preparing its members for opportunities and challenges such as healthcare reform, technological advances and economic uncertainty will be critical. Information on the newly elected leaders can be found in Executive News, pages 86–92.

Annual Membership Meeting

ACHE's 2009–2010 Chairman, Charles R. Evans, FACHE, president and CEO, International Health Services Group, Alpharetta, Ga., presided over the Annual Membership Meeting. During the meeting, ACHE President and CEO Thomas C. Dolan, PhD, FACHE, CAE, provided an overview of ACHE's progress in implementing the strategic plan.

Board of Governors Meeting

ACHE's Board of Governors met on March 20 and March 23, 2009, in Chicago. During the meetings, the Board reviewed ACHE's 2008 financial statements and approved the 2009–2010 committee

appointments. Following are other meeting highlights.

Progress Reports

The Board received the 2008 year-end operational report and achievement of performance objectives and reviewed progress on strategic plan implementation.

Addressing the Challenges of 2009

Given the current economic environment, the Board and staff discussed ACHE's plans for assisting affiliates during this period and safeguarding ACHE's resources for the future.

Review of Survey Findings

The Board reviewed the results of ACHE's 2008 Affiliate Needs Survey. The survey provides ACHE leadership with affiliates' views of existing services and ways ACHE can better meet their needs.

The Board also previewed ACHE's new affiliates-only group on the social networking site LinkedIn. In addition, Alyson Pitman Giles, FACHE, chair of the ACHE Nominating Committee, met with the Board for a discussion on ACHE's leadership needs for the future.

The next meeting of ACHE's Board of Governors is scheduled for June 28–30, 2009, in Atlanta.



Dawson



Fahrlander



Johnson



Olson



Ramirez



Tucker

Elaine I. Bauer, FACHE, to vice president, Strategic Initiatives, Catholic Health Association of the United States, Washington, D.C., from vice president, Strategy Development, Catholic Health East, Newtown Square, Pa.

Robert Brooks, FACHE, to vice president, Clinical Operations, Methodist University Hospital, Memphis, Tenn., from administrator, Ambulatory Care Services, Trumbull Memorial Hospital, Warren, Ohio.

Anthony L. Dawson, FACHE, to associate medical center director, W.G. (Bill) Hefner VA Medical Center, Salisbury, N.C., from assistant medical center director, Richard L. Roudebush VA Medical Center, Indianapolis.

Jason R. Fahrlander, FACHE, to COO, Memorial Health System, Colorado Springs, Colo., from senior vice president, Parkland Health & Hospital System, Dallas.

Ellen A. Feinstein, FACHE, to service line director, The Children's Hospital of Philadelphia, from assistant vice president of Oncology, Virtua Health, Marlton, N.J.

Frank R. Fortier to director, Clinical Affairs and Quality Care, American Academy of Physician Assistants, Alexandria, Va., from neurosciences physician assistant, Inova Fairfax Hospital, Falls Church, Va.

Michael T. Johnson, FACHE, to CEO, Southern Hills Hospital and Medical Center, Las Vegas, from COO, Creighton University Medical Center, Omaha, Neb.

John D. Julius to CEO, St. Joseph's Hospital, Parkersburg, W.Va., from interim CEO.

Stephen H. Lockhart, MD, PhD, to vice president/chief administrative officer and associate vice president, Medical Affairs, St. Luke's Campus of California Pacific Medical Center, San Francisco, from medical director, Surgical Sciences.

Robert S. Miller, FACHE, to COO, St. Elizabeth's Hospital, Belleville, Ill., from assistant administrator.

Shannon C. Novotny, FACHE, to associate director/COO, G.V. (Sonny) Montgomery VA Medical Center, from strategic planning and business development manager, VA Heart of Texas Network, Arlington, Texas.

JoAline A. Olson to vice president, Clinical Innovation, Adventist Health, Roseville, Calif., from president/CEO, St. Helena (Calif.) Hospital.

John D. O'Neil to president/CEO, St. Vincent's Health System, Birmingham, Ala., from president/CEO, Our Lady of Lourdes Memorial Hospital, Binghamton, N.Y.

Scott H. Perra, FACHE, to president/CEO, Faxton-St. Luke's Healthcare, Utica, N.Y., from executive vice president/COO.

John W. Powers III, FACHE, to engagement manager, IMS Solutions, San Antonio, from administrator, 314th Medical Group, Little Rock Air Force Base, Ark.

Andrew Ramirez to chair, Health Care Practice Group, Lathrop & Gage, Overland Park, Kan., from chair, Healthcare Department.

Susan M. Roman to clinical services administrator, Taylor Regional Hospital, Campbellsville, Ky., from CEO, Middlesboro (Ky.) Appalachian Regional Healthcare Hospital.

Jessie L. Tucker III, PhD, FACHE, to senior vice president and administrator, Lyndon B. Johnson General Hospital, Houston, from COO, Womack Army Medical Center, Fort Bragg, N.C.

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The American College of Healthcare Executives extends its congratulations to those ACHE affiliates who recently received awards recognizing their contribution to healthcare management.

Derrick B. Billups, FACHE, value analysis manager, Charleston (W.Va.) Area Medical Center, received the Early Career Healthcare Executive Award from the Regent for West Virginia.

Cynthia A. Braseth, administrative director, Altru Health System, Grand Forks, N.D., received the Regent's Award from the Regent for North Dakota.

Waleska Crespo, administrator, Hospital Hermanos Melendez, Bayamon, Puerto Rico, received the Early Career Healthcare Executive Award from the Regent for Puerto Rico.

Barry L. Davis, FACHE, vice president, Operations, Arkansas Methodist Hospital, Paragould, received the Senior-Level Healthcare Executive Award from the Regent for Arkansas.

Christopher Fraser, director, Operations and Community Relations, Westside Family Healthcare, Wilmington, Del., received the Early Career Healthcare Executive Award from the Regent for Delaware.

Laura L. Goldhahn, FACHE, administrator, The Summit: Kalispell (Mont.) Regional Medical Center, received the Senior-Level Healthcare Executive Award from the Regent for Montana.

William M. Gracey, FACHE, COO, Lifepoint Hospitals, Brentwood, Tenn., received the Senior-Level Healthcare Executive Award from the Regent for Tennessee.

Leo F. Greenawalt, JD, FACHE, president/CEO, Washington State Hospital Association, Seattle, received the Senior-Level Healthcare Executive Award from the Regent for Washington.

Robert L. Harman, FACHE, CEO, Grant Memorial Hospital, Petersburg, W.Va., received the Senior-Level Healthcare Executive Award from the Regent for West Virginia.

Will J. Henderson, LFACHE, formerly president, Queen's Medical Center, Honolulu, received the Senior-Level Healthcare Executive Award from the Regent for Hawaii/Pacific.

Kevin Kincaid, director of Radiology, Grinnell (Iowa) Regional Medical Center, received the Regent's Award from the Regent for Iowa.

Clinton W. Mickle, administrative director of Cardiovascular Services, St. Vincent Infirmiry Medical Center, Benton, Ark., received the Early Career Healthcare Executive Award from the Regent for Arkansas.

Terrence M. Murphy, FACHE, executive vice president/COO, Bayhealth Medical Center, Dover, Del., received the Senior-Level Healthcare Executive Award from the Regent for Delaware.

Catherine M. Murphy Thomas, administrative services manager, Yakima (Wash.) Valley Farm Workers Clinic, received the Early Career Healthcare Executive Award from the Regent for Washington.

Vanda L. Scott, EdD, FACHE, CEO, Select Specialty Hospitals, Knoxville, Tenn., received the Senior-Level Healthcare Executive Award from the Regent for Tennessee.

Michael A. Slubowski, FACHE, president, Hospital and Health Networks, Trinity Health, Novi, Mich., received the Senior-Level Healthcare Executive Award from the Regent for Michigan.

Daniel L. Stanton, FACHE, administrator, Transplant Institute, Methodist Le Bonheur Healthcare, Memphis, Tenn., received the Early Career Healthcare Executive Award from the Regent for Tennessee.

Peter W. Thoreen, FACHE, president/CEO, St. Luke's Regional Medical Center, Sioux City, Iowa, received the Senior-Level Healthcare Executive Award from the Regent for Iowa.

Laura N. Vargas, CEO, UHS San Juan (Puerto Rico) Capestrano Hospital, received the Senior-Level Healthcare Executive Award from the Regent for Puerto Rico.

Joseph A. Wasserman, FACHE, president/CEO, Lakeland Healthcare, Saint Joseph, Mich., received the Senior-Level Healthcare Executive Award from the Regent for Michigan.

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This column is made possible in part by Ortho-McNeil.



Any Volunteers?

Effective volunteer recruitment and management leads to sustained commitment.

Are your chapter leaders maintaining long to-do lists? Do they handle all tasks or delegate them? Their best decision may be to delegate. Having a pool of trained, prepared volunteers may seem overly ambitious, but recruiting and managing helpers will make chapter functions easier and more fun for everyone involved.

Linda Ridge, president, OnPoint Solutions, an association management consulting firm in Chicago, encourages her clients to commit to recruiting new leaders. She says organizations must institutionalize the practice of volunteerism to create a sustainable pool of successful leaders. For example, try to recruit at least two new members to each of the chapter's committees or require that at least 20 percent of the committee be new members each year.

Successful committees need a balance between new and seasoned members. Experienced volunteers get refreshed by new ideas and energy, and newer members get to learn how the committee works and benefit from the skills of senior members. The experience also increases their commitment to the chapter with the added benefit of preparing them to step up to more senior roles as others roll off a committee, move or transition to a higher board position.

Recruiting New Volunteers

The most effective way to recruit new volunteers is to ask. If you see people take initiative or demonstrate certain skills, ask them to consider joining a committee or running for board positions. Ask a potential volunteer some key questions: What would you like to do? What would you like to learn more about? Have you considered joining the communications committee?

Another effective recruitment technique is making periodic calls for volunteers. Ask for volunteers regularly, not just when you have board positions to fill. Make it easy for members to volunteer by placing an electronic form on your Web site; in your newsletter, describe the activities of each of your committees and list the committee chair's e-mail address.

"Develop a list of bullet points about the personal and, especially, the professional benefits of volunteering," says Ridge. "Be sure all your officers, board members and committee chairs know those points. Encourage them to keep an eye out for talent and recruit for you."

Mark A. Hamilton, FACHE, vice president, Ambulatory Operations, University of Wisconsin Hospitals & Clinics, Madison, and president,

American College of Healthcare Executives—Wisconsin chapter, says the chapter has so many active volunteers because asking people to help is part of everything the chapter does. "At every meeting, we ask for volunteers," says Hamilton. "On our Web site, newsletter and e-mail broadcasts, we list our committees and where we have openings to fill. Because we have several committees and five regional councils, we have several projects for anyone who raises his or her hand. Our entire board helps with the recruitment effort."

Recycling Volunteers

Chapter past presidents or a previous Regent may have valuable skills and energy they would still like to contribute to their chapter. Consider asking them to fill new roles, chair a new committee or serve as advisors. Stephen C. Waldhoff, FACHE, chief administrative officer, Albert Lea (Minn.) Medical Center, and former Regent for Minnesota, is the new president-elect for the Minnesota Healthcare Executives. After Waldhoff finished his term as Regent he continued to serve as a board member for the chapter.

Orienting and Managing Volunteers

Once you have secured new volunteers, you want to ensure they can be effective in their roles. Consider putting on a one-hour orientation for

This column is made possible in part by Johnson Controls, Inc.



The most effective way to recruit new volunteers is to ask. If you see people take initiative or demonstrate certain skills, ask them to consider joining a committee or running for board positions.

new volunteers in a relaxed setting. Spark some interest by calling it an emerging leader's workshop or a leader's update event. Build social time into the program and allow for networking. Have three to four key

chapter leaders discuss what they do and how their committee activities add to the chapter experience. If you want to make a more formal presentation, keep it to a short, informative overview of the chapter, and make the rest of the meeting an informal, relaxed event. A key technique is to assign one person the job of greeting attendees and introducing them to a few others. If you have enough experienced people available, pair one with each newcomer for the entire evening to create a comfort zone for first-time volunteers.

Volunteering should be fun. New helpers may be turned off to the process if there are lots of rules and tight structures. While there may be certain rules and timelines you need to

follow, new volunteers might have great ideas and should be encouraged to share them with the committee.

Increase the comfort level by introducing new volunteers at their first meeting and getting them involved from the start. If you are in the enviable position of having more volunteers than positions, keep the untapped volunteers in the loop by adding them to any appropriate e-mail broadcasts and sharing minutes from the meetings. These communications may help sustain their interest; you may have an unanticipated opening or a special project for them.

Check back with your volunteers periodically. Leaders who are managing volunteers too often fail to ask

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how the volunteer experience is going. Find out any barriers to accomplishing their volunteer work and try to eliminate them.

Managing Millennials

According to Ridge, there are fewer generational differences than one might think. Desire for meaningful, rewarding experiences is ageless—differences center more on work style preferences. For example, mature leaders prefer face-to-face work modes, while younger volunteers are often more comfortable working electronically. Senior volunteers tend to prefer traditional, hierarchical structures, while younger volunteers are seeking more dynamic, collaborative experiences.

There are three keys to success here, says Ridge. First, help experienced and emerging chapter leaders understand each other's preferences so they don't rub each other the wrong way. Second, find ways to blend the different work styles so everyone gets at least some of what they prefer. Third, clearly describe the desired outcome, budget and time parameters; then let the person who is expected to do the work decide for himself how he will do it.

Giving Recognition

Also critical to maintaining a pool of effective volunteer leaders is providing appropriate recognition. Recognize your volunteers as publicly and as often as possible. At events for which they played a part, acknowledge them individually instead of as a group. List the accomplishments of volunteers and include the names of

.....
Leaders who are managing volunteers too often fail to ask how the volunteer experience is going. Find out any barriers to accomplishing their volunteer work and try to eliminate them.
.....

their employers. Employer visibility and acknowledgment often help encourage employer support of volunteerism. The more visibility you give volunteers, the more chapter members you will have who will want the same experience.

What's Next at ACHE

In 2009, with the assistance of Ridge, the Division of Regional Services will be developing tools and resources for chapters to use to recruit, manage and recognize volunteers. Be on the lookout for updates on this project at ache.org/chapters and in your chapter leader's monthly newsletter and information packets.

To find your ACHE chapter, search the online Chapter Directory at ache.org by entering your ZIP code on the left side of the page. Then contact the chapter officials listed for information on how you can get involved. To discuss your ideas for chapters, contact the Chapters Committee's ACHE staff liaison, Desmond J. Ryan, FACHE, CAE, associate director in the Division of Regional Services, at (312) 424-9325 or dryan@ache.org.


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