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HEALTHCARE EXECUTIVE

The MAGAZINE FOR HEALTHCARE LEADERS VOLUME 30, NUMBER 5 • SEPTEMBER/OCTOBER 2015



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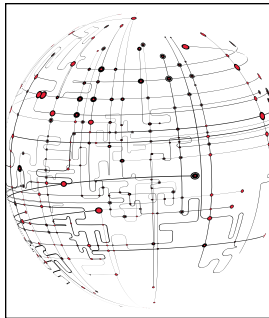


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Task Force Recommendations Address Challenges Leaders Face

In 2014, ACHE developed a Professional Development Task Force, chaired by Immediate Past Chairman Christine M. Candio, RN, FACHE, and 10 leaders in key roles from hospitals and healthcare systems. The committee met to identify how ACHE can successfully address the challenges members and the healthcare community face and the competencies they need to succeed. As a result, members can expect to see new education offerings from ACHE.

The task force also created the ACHE Healthcare Leadership Competency Framework. This is the first time ACHE has created competencies that address all levels of healthcare leaders' professional development and align with today's core and ever-changing healthcare environment. The framework can act as a road map for senior leaders as they enhance their professional healthcare knowledge. To match the information outlined in the framework, ACHE created a number of new programs addressing topics such as change management, population health and performance improvement.

The task force also identified opportunities to align ACHE content with delivery channels to maximize the impact of the content based on the audience and setting. One of these opportunities is to offer customized, detailed education onsite at individual healthcare organizations to help them meet the demand for in-house training. Another includes developing offerings for clinicians transitioning to executive leadership roles.

For more information or to view the report and the ACHE Healthcare Leadership Competency Framework, visit ache.org/ProfessionalDevelopmentTaskForce.



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Jennifer A. Williams

Defining Your Population Health Approach

The biggest social determinant of a person’s health is his or her ZIP code, according to population health expert David B. Nash, MD.

“ZIP code is destiny,” Nash told attendees of ACHE’s Congress on Healthcare Leadership this past spring, explaining that 85 percent of a population’s well-being is dependent on factors such as the geographical area of residence, socioeconomic status, crime rates, access to fresh food and more.

There’s a way hospitals can use ZIP codes to identify the geographical areas where the sickest patients and most frequent users of care reside, Nash explained during Congress. With that information, leaders can home in on the socioeconomic factors that affect the health of people in these areas—and can work with community groups to address those factors. You’ll find strategies for using data to inform population health management in our cover story, “Using Technology to Map Out a Population Health Strategy,” pages 10–20.

Also in this issue, view case studies of organizations that have found new ways to use technology to improve health outcomes in “Leading IT Innovation in Care,” pages 22–30.

Our special feature, “It’s Time to Take a New Look at Inclusion in Healthcare Organizations,” pages 34–40, introduces ACHE research that offers insight on how healthcare leaders can prepare their organizations for the changing demographics. ▲

Correction

In the Cardinal Health advertorial featured in our May/June issue, “Revolutionizing the Supply Chain for High-Value Inventory,” the email address for Rebecca Hellmann, vice president, services for Cardinal Health, was misspelled. She may be reached at GMB-CIMS@cardinalhealth.com. We apologize for the error.

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Deborah J. Bowen,
FACHE, CAE

Back to School

It is no secret that it is not business as usual in healthcare.

The job of leadership has always been complex; however, new playbooks now require that leaders embrace change, navigating the current environment while paving new paths to better serve patients and communities.

Last year, ACHE conducted a survey of select chief learning officers to ask how their organizations are developing healthcare leaders to take on new challenges. They agreed that new leadership styles and competencies are needed to drive critical initiatives around delivering value-based care, ensuring patients' health is effectively managed across the continuum of care, and managing the shift from hospital-based care to care provided in community-based settings. In short, the need for healthcare executives to expand their professional competencies and leadership capabilities has never been greater.

Taking charge of your professional development may be what differentiates you as a leader. Consider the following action steps.

Conduct a periodic self-assessment.

Using the process of self-assessment to take stock of your professional

development needs is a good way to start. Many tools are available, including ACHE's Healthcare Executive Competencies Assessment Tool, located via ache.org/careeredge.

Participate in learning—both within and outside your organization. While keeping up to date on your knowledge of healthcare and healthcare leadership is important, reaching out to other industries and disciplines for insight on effective leadership approaches also is key. Including others from your organization in your professional development experiences, such as clinical leaders, also can provide the opportunity for valuable exchanges.

Many leaders are looking globally for new approaches to improving outcomes and reducing costs. Although a number of options exist for these exchanges, one unique educational opportunity co-sponsored by ACHE, the American Hospital Association and the International Hospital Federation is coming to Chicago this fall for the first time in more than a decade. Look for details on page 72.

Seek solutions in a variety of formats. President Harry S. Truman famously

said, "Leaders are readers." Reviewing journals, books and other resources can be useful ways to gain new insights. Digital formats also have provided ample access to a wide variety of content. Other learning formats gaining ground include experiential learning such as on-site visits, professional certification and online courses, to name a few. More and more experienced leaders also are looking to executive coaching to work on specific challenges.

Give back. As leaders contributing to the field, this is a responsibility we all share. Presenting a case study on a recent project or initiative can help others doing similar work. The healthcare community also provides ample opportunity to network with peers both nationally and locally at trade and professional organizations. Networking is a powerful tool that can help you engage with other healthcare professionals while contributing to the development of others.

There has never been a more important time to advance our skills and leadership effectiveness. By developing new competencies and supporting the development of others in our field, healthcare leaders can better serve their patients and secure a sound future for our profession. ▲

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



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Using Technology to Map Out a Population Health Strategy

By John M. Buell



Do you know who your high-risk patients and high utilizers are? More important, do you know precisely where they live?

Population health expert David B. Nash, MD, who presented at ACHE's 2015 Congress on Healthcare Leadership, believes knowing the answer to those two questions is vital for successful population health management. But without adequate technology to identify these at-risk patients, improving the health of a population will be extremely difficult.

"The most important five-digit number I need to predict your health status and well-being is your ZIP code, bar none," says Nash, dean of the Jefferson College of Population Health, Thomas Jefferson University, Philadelphia. "It's not your cholesterol level or your blood pressure number or your age. The No. 1 health predictor in 2015 is your ZIP code."

In many cities, large disparities in health can be found among pockets of populations that live short distances from each other. For example, babies born to mothers in Maryland's Montgomery County and Virginia's Arlington and Fairfax Counties can expect to live six to seven years longer than babies born to mothers in Washington, D.C.—just a few subway stops and one ZIP code away, according to the Robert Wood Johnson Foundation's Commission to Build a Healthier America, which publishes maps that illustrate disparities in life expectancy within cities (see the exhibit on page 16). In the New Orleans area, the gap is dramatically wider.

Using Technology to Map Out a Population Health Strategy

“In other words, where you are on the map predicts your life span,” Nash says. “If we use technology to analyze the small percentage of patients who live in particular ZIP codes and use the data to determine ways to effectively improve care coordination and delivery, we will make progress in improving the health of these individuals while reducing waste.”

Discussions around population health management have taken on greater urgency since this expression was coined more than 10 years ago. Today, a variety of definitions for population health exist among healthcare executives and others, but all agree: Healthcare organizations cannot manage population health effectively without the technological capabilities and infrastructure to first identify populations most in need of healthcare interventions and then track the results of programs put in place to improve health for these patients.

All of the big healthcare IT firms are furiously creating population health software and applications to help hospitals, health systems and physician practices identify and manage high-risk, high-cost patients—such as the 20 percent of Medicare patients who consume 80 percent of costs.

“IT providers know the ability to identify healthcare superusers and at-risk patients is the pot of gold,” Nash says. “If we can find and better manage these 20 percent of patients, we have a fighting chance of reducing healthcare costs.”

Getting There From Here

A first step healthcare organizations can take in identifying their most at-risk patients and those who may become at risk is to create a patient registry, similar to the work Jeffrey Brenner, MD, in Camden, N.J., conducted in the late 1990s by sifting through thousands of billing records in spreadsheets. Today, sophisticated IT tools are available that make the process of creating a registry more efficient and effective.

“Without a patient registry, you can only manage what you measure,” Nash says. “You have to know who the population is.” Basic EHR systems are terrific at handling billing and other “back office” functions, Nash says, but to identify segments of the population most at-risk, data analytic capabilities are needed.

“The use of data analytics allows me to slice the patient information I already have in a number of ways,” Nash says. “For example, if I’m a primary care physician and want to practice population health management, I need a patient registry. Once I have a registry, I can run an analysis of a particular set of patients—such as patients who have diabetes—and examine how effectively I’m caring for this population of patients. I can then run analytic functions that compare my performance against regional and national benchmarks. Next, I can identify gaps in performance and use the data to help determine ways to improve. At the ground level, the registry function is the linchpin of making population health management a practical reality.”

But simply identifying patients who are most in need of coordinated care

“The most important five-digit number I need to predict your health status and well-being is your ZIP code, bar none.”

—David B. Nash, MD, Jefferson College of Population Health, Thomas Jefferson University

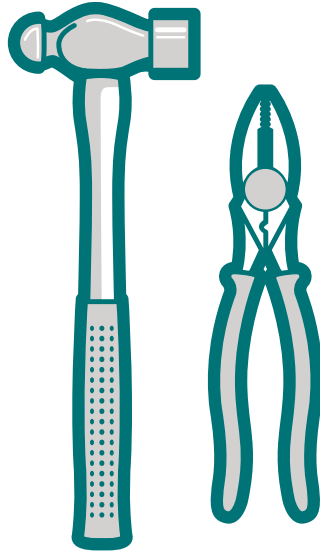


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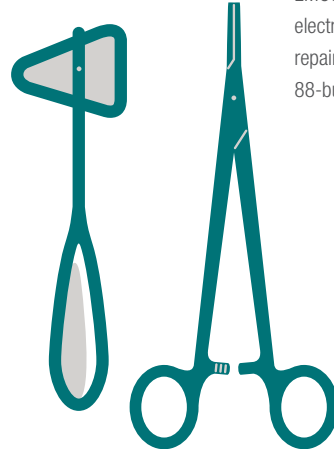
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management now isn't enough, according to Brian Silverstein, MD, managing director of HC Wisdom, Chicago, which provides population health management advisory services and operational assistance.

"The notion that 20 percent of a particular population drives 80 percent of cost in healthcare holds true, but just because you identify these patients as high cost today is not an indicator they will be high cost tomorrow," says Silverstein, an ACHE member. "The trick to this is to determine who will be high cost in future."

To attain the level of precision required to predict the future needs of at-risk patients, precise information in a number of categories—including socioeconomic information, family background and mental health factors—needs to be collected from patients and then analyzed. "What drives future healthcare utilization for most at-risk patients on an individual basis is more related to behavioral issues, genetics and social and cultural factors," Silverstein says.

"If you rely solely on historical and utilization data to forecast an individual's health needs, you are not including the things that are really meaningful," he says. "The ability of an EHR system to help healthcare teams successfully manage the health of a population—in terms of separating a population into segments and

identifying groups of people who have life needs and creating intervention programs to address those needs—is limited. What healthcare teams need is the ability to marry this information with predictive data and to leverage these data to redesign care for specific groups of people."

First Steps Toward IT-Based Health Management

It remains to be seen whether efforts to use data to redesign care for specific populations will prove widely successful, but there are many signs of progress. For example, early data from the accountable care organization demonstration projects launched by the Centers for Medicare & Medicaid Services show such efforts have reduced per capita Medicare spending. Similar success are being shared by hospitals and health systems of all sizes.

"If you rely solely on historical and utilization data to forecast an individual's health needs, you are not including the things that are really meaningful."

—Brian Silverstein, MD
HC Wisdom

"The early outcome measures are good," Nash says. "So if we can reduce spending and improve outcomes, we will have found the Holy Grail for population health management."

The following are three examples of organizations that have leveraged IT and data analytics to improve population health management.

Aurora Health Care, Milwaukee.

Aurora Health Care is a network of 15-hospitals in the Milwaukee area. Using IT capabilities beyond what its EHR system offers, the organization shares data with primary care physicians to better manage chronically ill patients. Data analysts review clinical and insurance claims data and perform predictive analytics to identify patients with

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congestive heart failure and those with chronic obstructive pulmonary disease and share the information with clinical specialists who can more proactively manage their care.

The system's population health journey began in 2012. "We wanted to have the data to drive the direction we wanted to take operationally," says Sylvia Meltzer, MD, senior vice president and CMO, Aurora Health Care. "The first step was to examine our populations, develop an understanding of where we sit compared

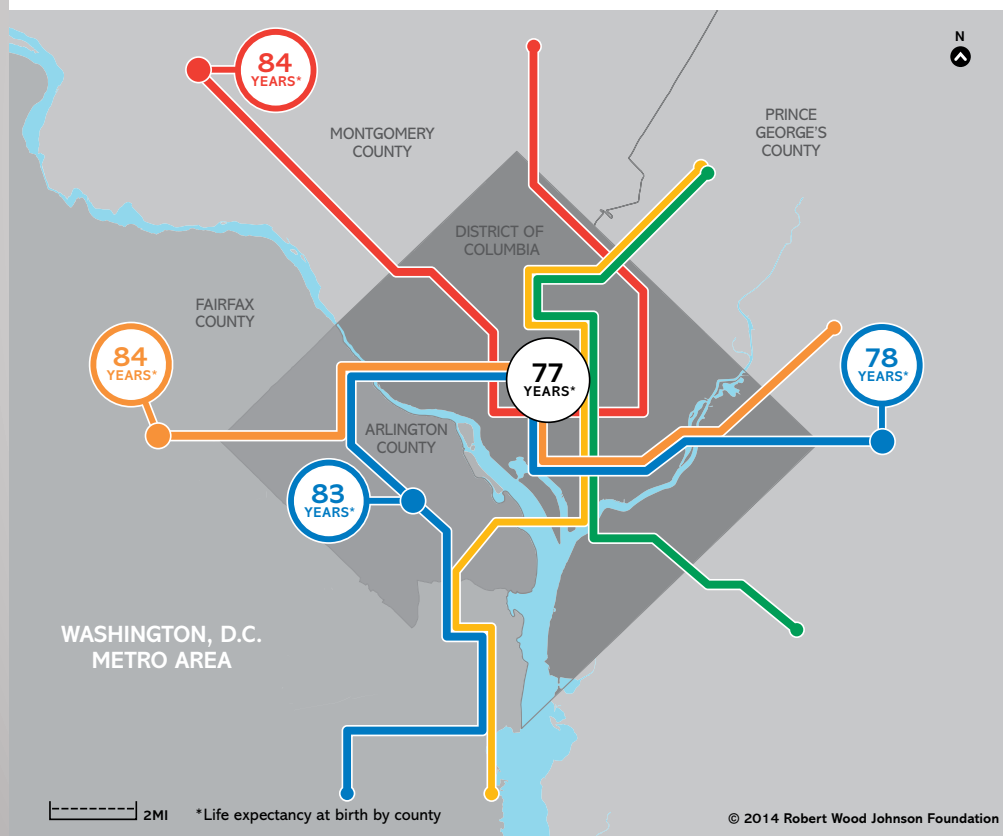
with other organizations, and determine where our greatest opportunities were."

Aurora Health Care uses a single EHR for all its facilities, but to attain the kind of high-level, hyper-specific data necessary for effective population health management, the organization invested in an additional IT platform—a population health and clinical and claims-based analytical tool.

"We can look at clinical and insurance claims to get a holistic view of where opportunities lie for population health management," says Laura Spurr, director, medical group operations, Aurora Health Care Medical Group.

Your ZIP Code May Be More Important to Your Health Than Your Genetic Code

Washington, D.C., Metro Area



The tool provides an additional layer to conduct national benchmarking and sophisticated statistical analysis, such as predictive analytics the organization was unable to previously achieve. Staff now have the ability to identify patients in different disease cohorts exhibit varying levels of risk of being admitted to the hospital.

"We run our entire population through that tool," Meltzer says. "And based on information that comes out through statistical modeling and analysis, it predicts what cohorts are highest risk. That's how we selected congestive health failure and COPD as our two high-risk populations to focus

upon. Once you dive into the data, it's not about managing one disease, but the whole patient."

Already, Aurora Health Care's efforts have resulted in a 60 percent reduction in hospital admissions for heart failure-related causes compared with the previous year, and a 20 percent reduction in all cause admissions.

"We just started on our journey, and we've experienced very impressive results so far. Now it's time to enhance what we have been able to do well," Spurr says. "How do we look not just at the impact of our efforts on one patient or interaction at a time, but on an entire population? To do that, we need the technology and tools to analyze the data in multiple ways."

A CEO To-Do List: 7 Strategies for Better Managing Population Health

The following are the top seven things David Nash, MD, dean of the Jefferson College of Population Health, Thomas Jefferson University, Philadelphia, recommends hospital and health system leaders consider to effectively manage population health.

Begin population health management efforts with their employee population. "Hospitals and health systems should be the leaders in taking care of their own employees and dependents," Nash says.

Keep the well "well." "This sounds obvious, but it isn't," Nash says. "The idea—which was first promoted by health and wellness industry pioneer Dee Edington of the University of Michigan—is to keep healthy people healthy by providing services such as gym memberships and nutritional advice. If you forget to take care of those who are taking care of themselves, you could be in a jam further down the road."

Provide appropriate guidance for those who will lead patient-centered medical homes. "Physicians typically will be charged with this effort, but they

need training around how to collaborate successfully with other providers and how to coordinate the work of each member of a patient's healthcare team—physicians, nurse practitioners, dietitians, social workers and others—to optimize care and value," Nash says.

Use patient registries. Patient registries—collections of data for patients with a specific diagnosis or condition or who have undergone a particular procedure—enable physicians to close the loop on the care of their patients and analyze how well their patients' health is being managed in comparison with similar populations cared for by other physicians. "Once the physician realizes how he is performing against his peers, this provides teachable moments and opportunities to work with the physician to improve performance," Nash says.

Partner with retail clinics.

"Because the average diabetic visits the pharmacy 30 times a year and sees his or her endocrinologist twice a year, hospitals and health systems need to partner with retail clinics on patient education and training to more effectively manage the health of such patients," Nash says.

Partner with managed care plans.

"Some insurance companies have multiple accountable care organization partnerships with provider groups that have varying risk-bearing structures. Who knows more about managing risks than the managed care industry?" Nash says.

Provide funding for physician leadership training. "CEOs and board members need to allocate resources today to build the medical staff they are craving for tomorrow. This means providing funding for leadership training," Nash says.

Using Technology to Map Out a Population Health Strategy

St. Joseph Hospital, Nashua, N.H. The purpose of St. Joseph Hospital's population health strategy is twofold: become more agile in stratifying populations by risk and create interventions that influence improved patient outcomes.

Because the organization is self-insured, leaders believed the best way to gain experience in population health management was to start with its own employees and their dependents. St. Joseph struggled with rising insurance costs for its employee population and their families. By using data warehouse software to collect patient data from each of its five third-party administrators, the organization identified a small number of patients who use a disproportionate amount of healthcare resources.

"We get up-to-date information in near-real time on utilization by our employees and their dependents," says Richard Boehler, MD, CEO.

"And based on two years of historical data, we can identify and risk stratify those who are on our health plan. For instance, I can identify employees and dependents who are at risk of becoming high-risk patients and put in place intervention programs to positively influence outcomes.

"So if I have an employee with two or three risk factors for developing kidney failure, why not try to keep the employee out of that situation? We are in the early stages of this approach, and this is where the

greatest benefit lies. When you take people with risk factors and craft an intervention program for them, it can make a big difference in preventing a heart attack or stroke."

One initial benefit for the team at St. Joseph's is the feeling of empowerment team members gain through the data insights now available to them. For example, clinical staff are learning how to encourage responsible use of healthcare resources through population health management. In addition, care coordinators have the tools necessary to be more proactive in helping to optimize the health of their peers. Their efforts are having a financial impact on the health system: The organization projects \$1.8 million in cost savings in 2015 through this initiative.

Truman Medical Centers, Kansas City, Mo.

Population health has been a focus at Truman Medical Centers for many years. A safety-net hospital for a region that provides a great deal of uncompensated care, Truman is at risk for 40,000 lives—those who are unable to pay for their medical care.

When it comes to using technology to improve population health, Truman's recently implemented

HealtheRegistry tool, which is embedded in its EHR system, has a large potential impact on improving the health of at-risk patients. The tool allows the organization to identify, at the individual provider level, how certain at-risk patients are doing based on an assessment of a variety of measures for seven chronic diseases.

"We can slice and dice that information and identify providers and clinics that are doing better or worse than others. We then identify the sources of differences in performances so we

"We wanted to have the
data to drive the direction
we wanted to take
operationally."

—Sylvia Meltzer, MD
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Using Technology to Map Out a Population Health Strategy

can disseminate best practices,” says Jeffrey Hackman, MD, chief medical information officer, Truman Medical Centers.

The HealtheRegistry tool pulls data from Truman’s EHR to analyze specific groups of patients and their health status. “For example, we may have a diabetes registry that has several thousand patients, and we have 20 measures in that registry, so we know whether these patients have had a particular test or scheduled their doctor’s appointment. The goal is to look more at outcomes, rather than just process measures or things like how often they come to the ED.”

Truman uses patient data from facilities in its health system, along with population health data from local government sources. The health system then examines and analyzes the population and the needs of those within that population. This allows the organization to determine high-risk patients and high utilizers, as well as others who should be using Truman’s services but haven’t been getting the care needed.

“What we found in our analysis is that we had a very high volume of people with a large number of chronic medical conditions who either visited the ED or were admitted on a regular basis,” Hackman says. “As a result of our findings, we have focused in on our chronic disease management solutions.”

To manage population health effectively, Hackman believes the more data an organization can integrate from various sources, the easier it is to do. “In some cases, you’re limited to claims-based data, but it’s a good starting point,” Hackman says. “But when you layer in clinical results and clinical data, you get a larger view of what really needs to be done to move the meter on patients’ health.”

In the past 10 years, the use of IT to more effectively manage population health has reduced the health system’s ED visits and costs. Data analytics also has enabled Truman to illustrate the value of its efforts in precise detail—with reports generated quickly and easily. “Today, we can demonstrate the impact our efforts are having on controlling a patient’s blood pressure or glucose levels in a matter of hours or even minutes because data analysis allows us to gather this information quickly instead of manually reviewing thousands of charts,” Hackman says.

Moving Forward

Although many hospitals and health systems have touched on population health for years—and some are now using IT to enable them to zero in on certain at-risk patients and design-specific care interventions—the pace of change is quickening.

“Value-based economic incentives are pushing more organizations to focus on well-being rather than on sickness,” Nash says. “And I believe the evidence will continue to accumulate to support the central take-home message of population healthcare.”

That makes the need for tools and data that provide actionable insight on population health more important than ever.

John M. Buell is a writer with Healthcare Executive.

“Based on two years of historical data, we can identify and risk stratify those who are on our health plan.”

—Richard Boehler, MD
St. Joseph Hospital



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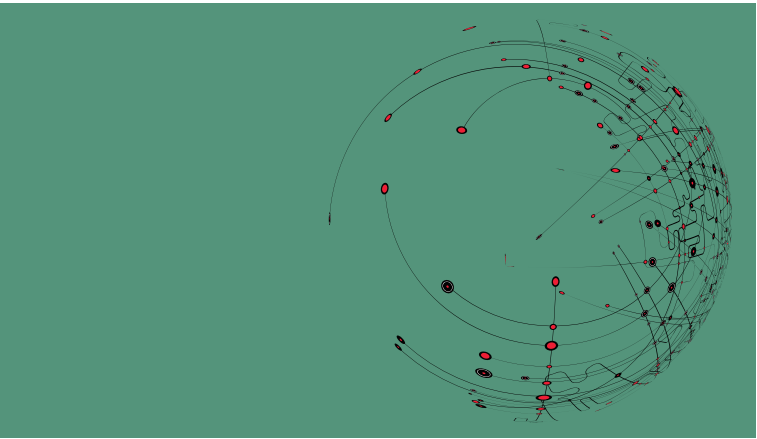
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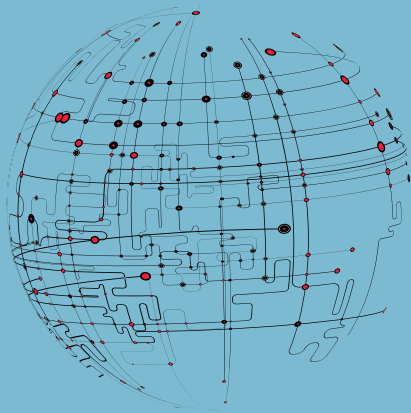
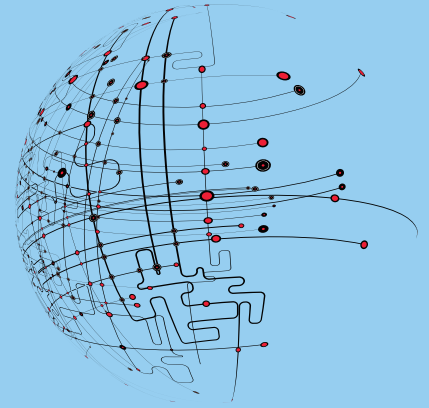
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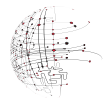
4 Case Studies Leading IT Innovation in Care

Healthcare leaders are using innovative technologies to transform patient care and ready their organizations for the challenges ahead.

by Laura Ramos Hegwer

From wearable devices that engage patients in their care to mobile apps that help manage population health, patient-focused technologies are helping providers transform care delivery. For many healthcare executives, such IT initiatives are not “projects” but rather strategic investments in their organizations’ long-term sustainability.

Across the country, leading healthcare organizations of all types and size are making patient-centered innovation a key component of their business strategy. Following are examples of organizations that are changing the way care is delivered and managed through the use of IT—and the lessons learned that could help your organization drive IT innovation in care.



Leading IT Innovation in Care

Finding Solutions to Achieve the Triple Aim
Vetting technologies that have the potential to improve care management and value can be particularly challenging for healthcare executives. But prioritizing initiatives focused on the Triple Aim can help leaders make tough decisions.



Photo credit: Intermountain Healthcare.

Intermountain Healthcare developed a systemwide telehealth infrastructure that fits within clinical workflows. The system is improving quality of care and the care experience while reducing costs.

“We don’t believe we can improve care quality, sustain costs and improve the care experience without innovating with IT in partnership with our clinical programs.”

Todd Dunn
Intermountain Healthcare

Intermountain Healthcare, Salt Lake City. In a wound care clinic in St. George, Utah, a physician dons a hands-free, wearable video camera that allows a patient to view a serious wound on the back of his leg for the first time. Using a tablet-based app, the physician can share the video with the patient and demonstrate how to dress the wound step by step.

Leaders at Intermountain Healthcare are closely monitoring whether this technology can improve patient-provider education and, in turn, boost clinical outcomes. Using proven innovations to achieve the Triple Aim is part of Intermountain’s broader business strategy. “We don’t believe we can improve care quality, sustain costs and improve the care experience without innovating with IT in partnership with our clinical programs,” says Todd Dunn, director of innovation for the large, integrated health system that covers Utah and southern Idaho.

Case in point: Intermountain is testing a telehealth solution in all of its ICUs as an additional safeguard to monitor critical care patients. Based in a hub in Midvale, Utah, a remote team of 22 physicians and 20 nurses assists the bedside teams in monitoring 263 critical care beds across the system. Early results show the program can help reduce length of stay, mortality rates and complications in Intermountain’s community hospitals. By improving these outcomes, the telehealth solution also may help keep costs under control.

Intermountain, a HIMSS Nicholas E. Davies Award recipient for using IT to substantially improve patient outcomes, uses a centralized committee that includes clinical leaders, project managers, and operations executives who work together to review new technology. When vetting a new tool, such as remote patient monitoring that can be used in the patient’s home, leaders consider three key questions.

- How does this technology improve quality and help sustain costs?
- How does the technology make a clinician’s work easier?
- How does the technology help the patient?

“We look for a lot of evidence in those three buckets,” Dunn says. “It sounds simple, but those are the guideposts for our investments in IT initiatives.”

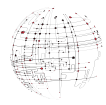
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Leading IT Innovation in Care

Reducing Harms in the ICU

Technology also is helping organizations redesign workflow in their ICUs to improve patient safety and get families more engaged in their loved ones' care.



Photo credit: Will Kirk/Johns Hopkins Medicine.

Rhonda Wyskiel, RN, patient safety innovation coordinator at Johns Hopkins Hospital and the Armstrong Institute for Patient Safety and Quality, checks the “harms monitor” to see which patient care tasks she needs to complete.

More than 230,000 patients have enrolled in Johns Hopkins' online patient portal, MyChart, which supports improved patient engagement and satisfaction. Through MyChart, patients can view portions of their medical record, communicate with providers, see test results and request prescription refills.

Johns Hopkins Hospital, Baltimore. As an ICU nurse, Rhonda Malone Wyskiel, RN, performs more than 200 tasks a day on any given patient. Missing any one of these tasks can put a patient's health in jeopardy. For example, failing to elevate a bed or delaying oral care for more than two hours can put a ventilated patient at risk for infection. Either one of these simple tasks can be missed as the care team juggles patients or changes shifts. Yet by using a tablet-based app, Wyskiel and other clinicians in the ICU have a better way to determine what actions they need to take to reduce a patient's risk of a ventilator-associated event as well as six other preventable harms.

The app is a key component of Project Emerge, a research project funded by a \$10 million grant from the Gordon and Betty Moore Foundation. The app pulls data from multiple information systems and continuously updates a harms monitor—a diagram that looks like a sonar map. Clinicians check the monitor on their tablets and can quickly see what actions they need to take to reduce patient harm based on simple red, yellow and green color coding. “This is at-a-glance information that we absolutely need as clinicians so we have more time to spend with patients,” says Wyskiel, who helped design the app in her role as patient safety innovation coordinator at the teaching hospital and the Armstrong Institute for Patient Safety and Quality.

The other key component of Project Emerge is a portal for patients and families they can access on a different set of dedicated tablets in the ICU. The patient and family portal is designed to improve communication between the care team and visitors to the ICU. For instance, family members can share their loved one's care goals and upload photos and list favorite music and television shows so staff can get to know patients on a more personal level.

A family involvement menu for the portal allows families to select from 10 daily care activities, such as shampooing, that help them assist the team caring for their loved one.

In the six months the patient and family portal has been in operation, Wyskiel has seen the beginnings of a cultural shift in the ICU. Rather than pushing families to the sidelines, clinicians recognize that families also can be experts in care.

“This portal is giving new insights to clinicians so they can build better relationships and trust, which is critical to patient-centered care,” she says. Not only is this the right thing to do, Wyskiel believes, but it also may help providers protect their reimbursement as more metrics are tied to the patient experience.



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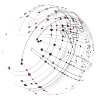
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Leading IT Innovation in Care

Connecting Rural Patients and Providers

Access to specialty and even primary care continues to be a major issue for rural providers. Telehealth platforms can connect patients with providers, but challenges still remain.



Photo credit: Grundy County Memorial Hospital.

Telehealth nurse Theresa Borcharding, RN, uses the telehealth platform with patient Michael Greiner for a visit with cardiologist Kalyana Sundaram, MD, at the Grundy County Memorial Hospital Specialty Clinics.

“The big challenge is encouraging providers to test the waters. Telehealth patients have generally been very happy with their care, and from a physician standpoint, the visits can often be scheduled for smaller time increments in between regular office visits. We still have a ways to go until we can more effectively convince providers of the benefits.”

Jennifer A. Havens
Grundy County Memorial Hospital

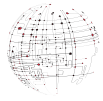
Grundy County Memorial Hospital, Grundy Center, Iowa. In 2010, the 25-bed critical access hospital received a \$1.8 million grant from the Broadband Technology Opportunities Program, funded by the American Recovery and Reinvestment Act. With its grant (plus \$528,000 in matching funds), GCMH has equipped 12 healthcare providers with video equipment to give patients better access to neurology, cardiology, oncology and other specialty services. Yet, the technology alone is not enough to improve access in rural areas, according to Jennifer A. Havens, CEO, and an ACHE Member. What providers in these areas need is greater physician buy-in, which is challenging when physician schedules are busy and appointments for some specialties are filled months in advance.

“The big challenge is encouraging providers to test the waters,” Havens says. “Telehealth patients have generally been very happy with their care, and from a physician standpoint, the visits can often be scheduled for smaller time increments in between regular office visits. We still have a ways to go until we can more effectively convince providers of the benefits.”

Another issue is that physicians usually do not have an IT person in their office to address glitches. “Technology is only wonderful when it works,” Havens says. “It could be working great on our end, but if the physician is having trouble on their remote end, that is a lost visit. After the first or second time the technology doesn’t work, physicians aren’t going to want to do it again.”

Despite these challenges, GCMH, which was named a “Most Wired” hospital by *Hospitals & Health Networks* in 2014, can count several wins for its telehealth strategy. For instance, orthopedic surgeons use the platform to round on their joint replacement patients, rather than having to drive 40 minutes to the hospital. GCMH also uses the telehealth technology to provide hospitalist coverage during off-peak hours. Additionally, the hospital is linked to nine EMS services and 10 schools on its telehealth platform, which allows it to provide training and education in the community.

As an affiliate of UnityPoint Health, GCMH implemented a sophisticated EHR that would have been impossible for the hospital to land on its own. Since the EHR went live in 2012, it has been a vital tool for improving communication and continuity of care. For example, physicians and post-acute providers who are not part of UnityPoint Health can access patients’ medical records through a secure link. “This is important for us in rural America, where a lot of physicians are still practicing independently,” Havens says. GCMH also plans to work with its health system to test mobile technologies to promote better care transitions and expand its telehealth strategies to fill gaps in primary care.



Leading IT Innovation in Care

Preparing for Value-Based Payment

As providers explore value-based payment models that put them in charge of managing populations, technology can help engage at-risk patients and streamline data reporting to monitor performance.



Photo credit: CentraState Healthcare System.

John Ulett, CentraState's vice president and CIO, discusses the design of workflows and order sets with Gabrielle Pinzon, MD, a physician informaticist.

Since implementing a workflow in its EMR to monitor levels of the antibiotic vancomycin, CentraState has reduced the incidence of missing lab tests between the third and fourth dose from six to eight per month to zero, improving patient safety.

CentraState Healthcare System, Freehold, N.J. Leaders at this not-for-profit community health system are considering adding a new tool that would allow them to send secure text messages to patients to improve compliance with treatment plans. “Instead of an app that would require a heart failure patient to log in and enter their weight every day, the tool would send a secure text to the patient asking if their weight had gone up,” says John Ulett, vice president and CIO. “If we don’t hear back from the patient, the nurse also reaches out.”

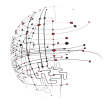
Ulett and other leaders at CentraState, which also was named a “Most Wired” hospital by *Hospital & Health Networks* in 2014, hope such a tool will improve clinical outcomes in recently discharged patients with chronic diseases and reduce costly readmissions, which will be critical as the health system takes on more risk in its payer contracts.

“CentraState Healthcare System has invested a tremendous amount of money and resources into utilizing technology for the clinical benefit of our patients,” explains John T. Gribbin, FACHE, president/CEO, a recipient of the CEO IT Achievement Award presented by *Modern Healthcare* in collaboration with HIMSS. “Clearly we recognize the potential that various software programs have to help clinicians and patients better manage both chronic and acute health concerns at home. We are particularly excited about the potential for mobile technologies to enhance personal accountability for maintaining good health.”

CentraState also has launched an initiative to automate collection of quality data across the health system. “There is a seemingly unending supply of quality data that we need to provide to various entities,” Ulett says. “In the long run, we can’t afford to hire nurses to do chart abstraction, so we want to automatically harvest the data out of the EHR when appropriate. Our big, audacious goal is to automate 100 percent of that collection.”

Using informaticists to improve workflows also is an initiative that is enhancing care management at CentraState. Leaders for the health system have leveraged the workflow engine in their EHR to develop 30 evidence-based care plans that standardize treatment for patients.

As they develop these care plans, leaders hope to minimize the time physicians need to feed the EHR with notes and data. CentraState has hired a physician informaticist and several nurse informaticists who reside outside of IT but work with the IT team to design smarter workflows and order sets. “Their goal is to have physicians interact with the EHR using the fewest clicks possible, and they can do that because they understand how physicians interact with patients,” Ulett says.



Leading IT Innovation in Care

8 Ways to Drive IT Innovation in Care

To effectively use IT to drive innovation, healthcare executives should consider the following lessons learned from other leading organizations.

1 **Harness ideas from outside firms, as well as clinicians and employees.**

Intermountain Healthcare has established a partnership with a healthcare consultant to investigate potential medical devices, digital health apps and other technologies proposed by outside companies. Intermountain also has developed a process for employees, especially clinicians, to submit their ideas for apps and other technologies to improve patient care. Called the Intermountain Foundry, the process allows employees to submit an application to receive funding for an innovative idea that improves the quality of care and helps contain costs.

2 **Leverage partnerships to gain access to sophisticated healthcare technologies.**

For example, leaders at GCMH leaned on their affiliation with UnityPoint Health to position the organization to become one of the first rural hospitals in the nation to implement an EHR. “As a \$35 million organization, we cannot purchase big-ticket items like a stand-alone EHR, but we can make sure we are at the table with our senior affiliate in the health system when those decisions are made,” Havens says. “When we heard that our senior affiliate was considering an EHR, we told those involved that we wanted to be the first rural affiliate to go live. As an organization, we run toward change instead of away from it.”

3 **Automate collection of quality data as much as possible.**

For example, CentraState uses a third-party tool to aggregate quality data from its physician-hospital organization into its private health information exchange so leaders can track performance over the course of the organization’s contracts with payers. Additionally, CentraState collects data from three post-acute providers in its health system to monitor quality across the continuum and prevent avoidable readmissions.

4 **Use technology to improve patient engagement.**

Intermountain has developed a mobile app called Health Hub, which allows patients to refill prescriptions, find doctors and clinics, and access the patient portal, where they can view their medical record or pay their bills. The app was designed with feedback from Intermountain’s patient engagement steering committee, which includes patients and families.

5 **Educate your board on IT as a business strategy.**

Havens of GCMH says CEOs and other senior leaders should make sure their board understands how various technology investments can make their organizations more sustainable.

6 **Consider interoperability issues when making purchasing decisions.**

“It’s one thing to choose an EHR to meet meaningful use, but if it doesn’t interface with other hospitals you work with, it is not removing any barriers,” Havens says. “Consider what the major players in your market have and get in alignment with them.”

7 **Focus on continuous improvement.**

Clinicians at Johns Hopkins Hospital continually provide feedback on their tablet-based apps in development so their colleagues from bioengineering and applied physics can make improvements to the next prototypes.

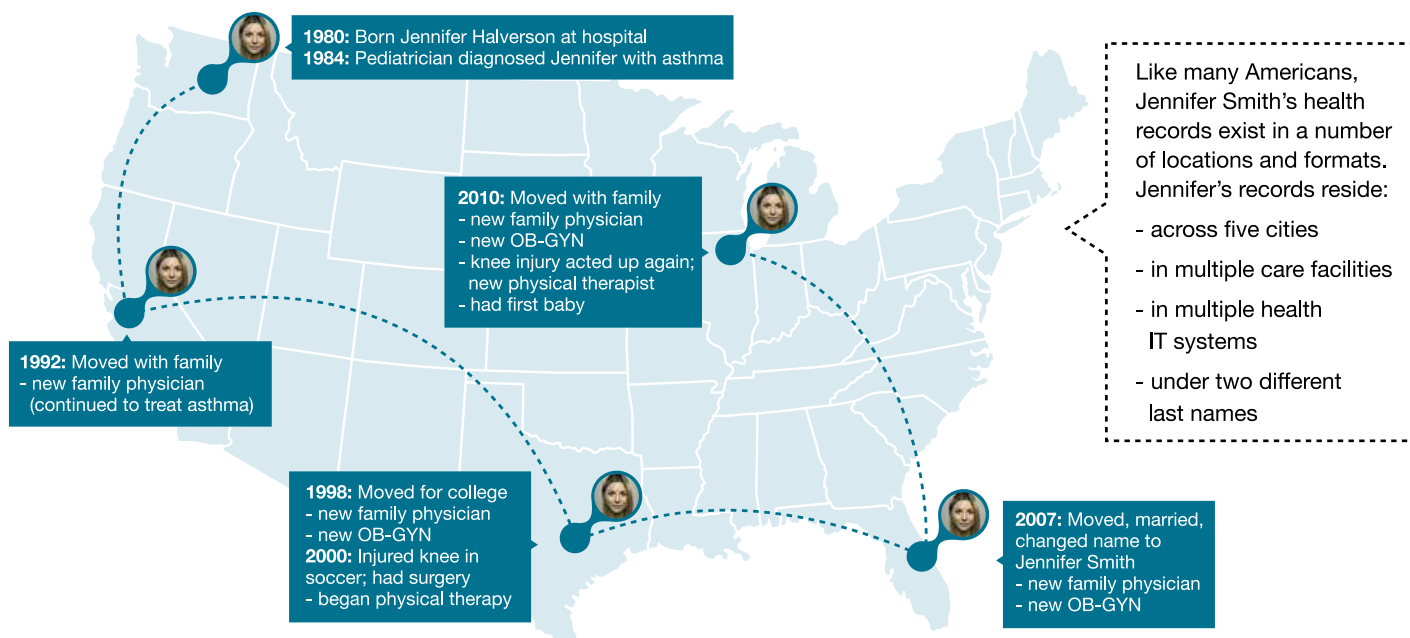
8 **Keep good people in IT.**

Experienced data analysts—particularly those with health-care experience—are hard to replace. To that end, leaders at CentraState are designing detailed career ladders to keep the team engaged in their work. As Ulett puts it, “The real focus of a leader has to be on people and not on the technology.”

Laura Ramos Hegwer is a freelance writer and editor based in Lake Bluff, Ill.

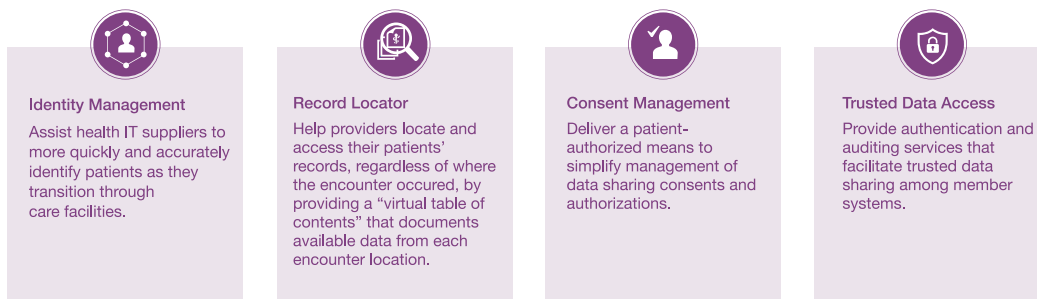
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Removing Barriers to Building a Nationwide Data Exchange

Health IT competitors are collaborating to build infrastructure and services that enable interoperability nationwide, supported by common standards and policies.

“The vendors who lead CommonWell coalesced because they felt the industry was facing a problem worth solving. Patient data should be accessible to everyone—it should not be something to compete on. This is the vision to which CommonWell is committed.”

—**Jitin Asnaani**
Executive Director
CommonWell Health Alliance, Boston

Between 2008 and 2013, the number of U.S. hospitals adopting at least a basic EHR system increased fivefold. While such rapid adoption is commendable, the ability to share those records among nonaffiliated, geographically diverse facilities continues to challenge the healthcare industry.

For the past two years, a group of leading technology vendors has united to address the issue of nationwide interoperability. Working together as CommonWell Health Alliance, these vendors recognized a greater cause was at stake and reached across competitor lines to ignite the effort. As a result, CommonWell members have created a real-world service that eliminates the barriers to sharing patient data and leverages the workflow clinicians already use.

“The vendors who lead CommonWell coalesced because they felt the industry was facing a problem worth solving,” says Jitin Asnaani, executive director, CommonWell Health Alliance, Boston. “Patient data should be accessible to everyone—it should not be something to compete on. This is the vision to which CommonWell is committed.”

What Is CommonWell Health Alliance?

From the outset, CommonWell—which was incorporated as a nonprofit trade association in 2013—wanted to create services that would allow providers to manage patient identity,

link patients across organizations and facilitate secure data access and exchange beyond one’s own system or community. With those tools, CommonWell hoped to enable its vendor members to give their customers complete patient health stories, including information from outside organizations and from different EHR systems.

CommonWell’s 29 members represent more than 70 percent of the acute care EHR market, according to KLAS Enterprises, and nearly a quarter of the ambulatory care EHR market, according to SK&A a Cegedim company. Members support the belief that provider access to this data must be built into HIT at a reasonable cost.

What Services Does CommonWell Provide?

CommonWell provides interoperability-enabling services that are embedded natively within vendors’ own software, not tacked on as an afterthought. This helps solve many of the challenges associated with interoperability and facilitates the exchange of healthcare data along the care continuum.

“Access to our service is built into the software of our members,” Asnaani says. “This is critical because clinicians will be less inclined to embrace something that requires switching to another program or opening a new window to access a patient record. Those extra steps create mental and technical barriers that are difficult to overcome.”

However, CommonWell members have built-in access to the organization’s services at the end point, so that they can use the software they already have in the workflow they already know. “The cool thing about [CommonWell is] it’s presented in the context of what the provider is used to seeing for that system,” says William “Tripp” Jennings, MD, system vice president, Medical Informatics Office—Palmetto Health, a South Carolina-based nonprofit health system. “We should have overcome these interoperability challenges years ago. It’s the right thing to do for patients.”



CommonWell's core services—which ensure that patient data can be securely, efficiently, seamlessly and accurately shared—include the following.

Patient identification and linking. CommonWell services provide quick and accurate identification of patients as they transition through various care facilities anywhere in the nation. “One of the key differentiators of our services is that they are entirely person-centric,” Asnaani says. “With most current health technology, users need to know where the data is located and then use the technology to pull the data from that point. It’s a very location-centric way of working and assumes that you know where the data is initially.”

Patient access, privacy and consent management.

Members can give their users a patient-authorized means to simplify management of data-sharing consents and authorizations. Patients who have given permission to have their health records accessible through the CommonWell Health Alliance network are associated with a unique “person” identifier that is linked to their existing “patient” records at each provider location.

Record locator and retrieval. By providing a “virtual table of contents” that documents available data from each encounter location as well as a “virtual librarian” who can find and retrieve the data, CommonWell services help providers locate and access their patients’ records, regardless of where care occurs. For this reason, Asnaani says CommonWell thinks of itself as a record locator service, not a health information exchange.

Trusted data access. CommonWell offers certification, authentication and auditing services that facilitate consistent and trusted data sharing among member systems. Data remains within the health system where it was collected, with CommonWell providing authentication and auditing to facilitate trusted data sharing among those member systems.

Most of its participating members have publically announced that they will offer CommonWell services free to their clients, including ACE’s Premier Corporate Partners athenahealth and Cerner.

What Makes This Coalition Groundbreaking?

CommonWell is open to all organizations that are committed to making patient data available to providers regardless of where care occurs. It has proven that when competitors set aside their differences and focus on competing on functionality not data access, everyone wins. Most important, patients have the opportunity to receive the best coordinated care possible.

“Rather than starting with a forced set of regulations, this initiative began with organizations that had already internalized the belief that highly accessible data should always follow the patient,” Asnaani says. He describes a recent board meeting attended by CommonWell members who are technically competitors.

Ultimately, Asnaani hopes that someday, access to patient health information can be considered on par with other national utilities—without boundaries or restrictions on locations or providers. CommonWell leaders see their efforts as a solid and significant step in that direction.

“It comes back to building upon and maintaining the momentum of our core mission,” Asnaani says. “If the entire industry embraces our belief that the services that enable interoperability should be as accessible as the ‘File’ menu of every software program, the incentive to raise the bar automatically moves for everyone.”

For more information, contact CommonWell Health Alliance at info@commonwellalliance.org or visit the organization’s website, www.CommonWellAlliance.org.



IT'S TIME TO TAKE A NEW LOOK AT INCLUSION IN

HEALTHCARE ORGANIZATIONS

New ACHE research offers insight on how healthcare leaders can prepare their organizations for changing U.S. demographics.

By Leslie A. Athey

Healthcare organizations have been addressing the issue of diversity in the workplace for decades; why revisit it now? A recent ACHE study shows racial and ethnic disparities and perceived lack of parity still exist in healthcare workplaces. Although some strides have been made, the data indicate that the median salaries of black respondents were still lower than that of their white counterparts, controlling for education and experience. Further, minority respondents were, in general, less likely to be in CEO positions than white respondents, less likely to report that race relations in their organizations were good and more likely to report their careers had been negatively impacted by discrimination.

Fully developing staff talent, treating staff fairly and being respectful of cultural issues in interactions with staff and patients are simply the right things to do. There are, however, two reasons to take a fresh look at inclusion and cultural competence. The U.S. Census Bureau estimates that within the next 30 years, the population of the United States—and therefore the workforce and patient population—will be mostly nonwhite. As healthcare organizations become increasingly complex, the demand for capable leaders increases. Organizations need to make sure they have the right policies for attracting and retaining talented staff and delivering quality patient care to be successful in a country with such rapidly changing demographics.

The findings in this article are based on a survey ACHE has conducted every five to six years since 1992. It compares the career attainments of male and female healthcare executives by race and ethnicity. Participants in the survey were sampled from the memberships of ACHE, the National Association of Health Services Executives, the National Forum for Latino Healthcare Executives and the Asian Health Care Leaders Association. The survey also was endorsed by the Institute for Diversity in Health Management.

Because those in the study were sampled from member lists, the results are indicative but not necessarily representative of all healthcare executives. The survey asked black, white, Hispanic and Asian healthcare executives about a number of topics related to their careers such as education, career progress, career experiences and attitudes about their current organizations. This article focuses on study results in three major areas: compensation, current position and job satisfaction. The full results from the research study are posted at ache.org/pubs/research/2014-Race-Ethnicity-Report.pdf.

COMPENSATION

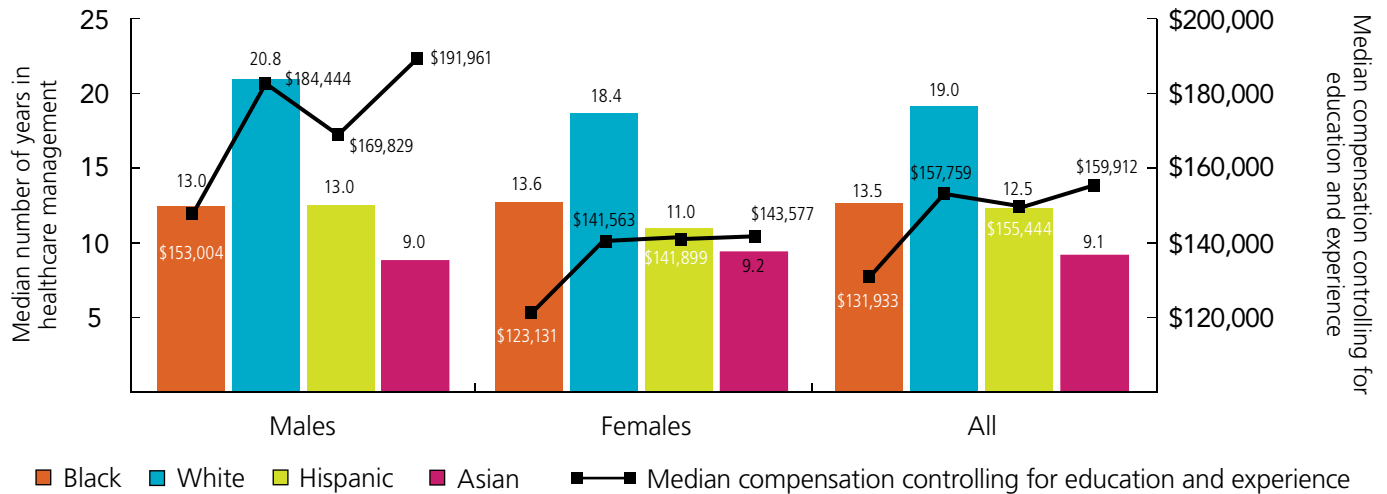
When level of education and number of years of experience are controlled, Asian and white men earned similar compensation. One of the positive findings from the 2014 study is that when education level attained and years of experience are controlled, Asian and white men in the survey earned virtually the same median salary in calendar year 2013: about \$192,000 and \$184,400, respectively (see the exhibit on page 36). This is an improvement from the 2008 study when, controlling for educational attainment and years of experience in healthcare management, we estimated Asian men earned 22 percent less than white men in the previous year.

Controlling for education level attained and years of healthcare management experience, Hispanic and black men earned less than white and Asian men. In 2014, taking education and experience into consideration, the previous year's earnings for Hispanic men were 8 percent less than those of white men. This represents progress since the 2008 study, when this figure was 14 percent. In 2014, however, previous year's earnings for black male executives, accounting for differences in education level attained and years of healthcare management experience, was 17 percent less than that of their white counterparts, showing no improvement over the 2008 results.



IT'S TIME TO TAKE A NEW LOOK AT INCLUSION IN HEALTHCARE ORGANIZATIONS

Predicted Mean Total Compensation 2013, Controlling for Education and Years of Experience and Median Years in Healthcare



Note: The actual (uncontrolled) median income for each race/ethnic and gender group is available in the full report in the Research area of ache.org.

Again, controlling for education level and years of healthcare management experience, white, Hispanic and Asian women earned similar salaries. Another positive finding from the study was that when differences in education level and years of experience were accounted for, the median salaries for white, Hispanic and Asian women in calendar year 2013 were virtually the same: about \$141,600, \$141,900 and \$143,600, respectively. This is also an improvement from the 2008 results, when Hispanic and Asian women earned roughly 10 percent less than white women in the previous year.


When education level and years of experience are controlled, black women earned less than white, Hispanic or Asian women. The results were not as positive for black female executives in the survey. In 2008, black and white women earned about the same salary in the previous year, controlling for education level and years of experience. In 2014, the adjusted median salary for black female executives was 13 percent less than that of white women.


CURRENT POSITION

A higher proportion of white men than minority men had attained CEO positions, but black and Asian men

are closing the gap. A higher proportion of white male executives (32 percent) held a CEO position at the time of the 2014 survey than did black, Hispanic or Asian men (20 percent, 25 percent and 9 percent, respectively). This may be due in part to the fact that minority men had attained fewer years of healthcare management experience than white men (see the exhibit). However, the proportion of black men in CEO positions was 62 percent of that of white men, a significant improvement from 2008, when this figure was 47 percent. Similarly, the proportion of Asian men in CEO positions was 28 percent of that of white men, up from 15 percent in 2008.

A higher proportion of white women than minority women had attained CEO positions, but the gap is widening for black and Hispanic executives. The proportion of white women executives (14 percent) in CEO positions in 2014 was almost the same as it was in 2008. However, in 2014, the proportion of black women holding CEO positions was 57 percent of that of white women; a drop from 2008 when it was 77 percent. Similarly, the proportion of Hispanic women occupying CEO positions was 78 percent of that of white women in 2014, a drop from 92 percent in 2008.



 Amy Georgeadis, CCC-SLP
Speech-Language Pathologist,
Community-based Aphasia Center

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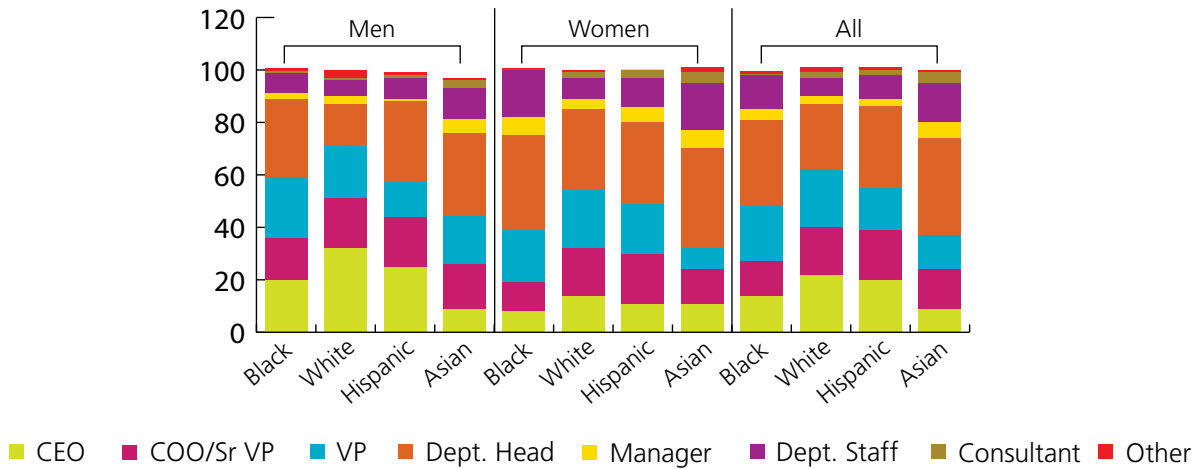


60 YEARS STRONG



IT'S TIME TO TAKE A NEW LOOK AT INCLUSION IN HEALTHCARE ORGANIZATIONS

Current Position by Race/Ethnicity and Sex (Percentages)



JOB SATISFACTION

Men and women in all racial/ethnic groups are largely satisfied with their jobs. A piece of good news from the study is that, within all racial and ethnic groups, most healthcare executives are happy with their jobs. About three-quarters or more of the study respondents said they were satisfied with their position, almost all identify with their organization by saying “we” rather than “they” when speaking about their companies and more than half intend to stay in their current jobs for the coming year.

Some minority executives were less satisfied with aspects of their jobs. Black respondents reported being less satisfied with their compensation, how they are treated when they make mistakes and the respect and treatment their supervisors give them than were members of any other racial or ethnic group in the study.

DIFFERING PERCEPTIONS OF RACIAL/ETHNIC EQUITY

There are clearly differing perceptions between white and minority respondents about the degree to which healthcare organizations have reached racial and ethnic parity in the workplace. Black respondents were about twice as likely as white respondents (81 percent versus 40 percent) to say more effort is needed to increase the proportion of racial/ethnic minorities in

senior positions in their organizations. Asian and Hispanic respondents fell between these two extremes, with slightly more than half agreeing more effort is needed to increase diversity among senior executives. Black respondents also were significantly less likely to feel positively about race relations in their organizations when compared to white respondents or members of the other racial and ethnic minorities in the study.

Minority respondents were less likely to report satisfaction with their career progress than white respondents, and they were more likely to report discrimination had negatively impacted their careers. More than 80 percent of white respondents reported being satisfied with their career progress, as were more than 75 percent of Asian and Hispanic respondents. However, only 67 percent of black respondents were satisfied with how they were meeting their career goals. Almost half of black respondents said their careers had been negatively impacted by racial or ethnic discrimination, as compared to about one-quarter of Asian and Hispanic respondents and 10 percent of white executives.

WHAT ARE ORGANIZATIONS DOING?

The survey results give us an idea of how prevalent different types of diversity initiatives are in healthcare organizations (see the exhibit on page 40).



IT'S TIME TO TAKE A NEW LOOK AT INCLUSION IN HEALTHCARE ORGANIZATIONS

Perceptions of Racial and Ethnic Parity in the Workplace

	Black	White	Hispanic	Asian
The amount of job security I have	74%	78%	78%	78%
The amount of pay and fringe benefits I receive for what I contribute to this organization*	58%	68%	67%	64%
The sanctions and treatment I receive when I make a mistake*	64%	74%	71%	70%
The degree of respect and fair treatment I receive from those who supervise me*	76%	82%	82%	83%
The degree of respect and fair treatment I receive from the employees I supervise	87%	92%	90%	88%
The amount of independent thought and action I can exercise in my job	81%	86%	87%	85%
Overall, how satisfied are you in your present position?	78%	84%	86%	82%
(N)	443	400	269	292

* Chi-square significant $p < .05$

The most common type of diversity program appears to be social gatherings for employees, which were reported by roughly three-quarters of survey respondents as being offered by their organizations. More than half of respondents reported their organizations had affirmative action plans, and about half said their organizations offered mentoring programs, diversity training for managers or a policy of seeking diversity in candidates considered for hire. Less than half of respondents said their organizations had a diversity committee, a manager responsible for diversity, a strategic or business objective to increase diversity, affinity groups or different types of diversity incentives for managers.

6 WAYS TO INCREASE DIVERSITY AND INCLUSION

We analyzed the relationship between the existence of diversity programs and the likelihood that minority executives would describe race relations in their organization as good (see the exhibit on page 40). That, combined with other results from the survey, leads us to make the following recommendations to healthcare organizations looking to increase diversity and inclusion.

Ensure equity in pay. Salary is by no means the only—or even, sometimes, the most important—reason people choose and remain in their jobs. It is, however, a tangible sign of the value the organizations place on individual staff members.

Organizations need mechanisms to periodically review compensation and ensure each executive's pay is based on his or her qualifications and responsibilities and in no way reflects biases relative to his or her gender or race and ethnicity.

Sponsor social gatherings for employees. The study showed the existence of social gatherings for employees was significantly related to minority executives feeling more positive about race relations in their organizations.

Establish mentoring programs. About three-quarters or more of minority executives in the 2014 survey reported having a mentor at some point in their careers, and mentoring programs were mentioned among the best practices to promote diversity in healthcare volunteered by respondents. In addition, the existence of mentoring programs was positively related to Hispanic and Asian respondents feeling good about race relations in their organizations. Mentors who provide advice, model positive behaviors and introduce protégés into networks of other executives are having a powerful impact on the field, yet only about half of survey respondents reported mentoring programs are in place within their organization. Healthcare organizations need to consider instituting or expanding effective mentorship programs.

Implement a policy of seeking diversity in candidates considered for hire. Both black and Asian respondents



IT'S TIME TO TAKE A NEW LOOK AT INCLUSION IN HEALTHCARE ORGANIZATIONS

Agreement With the Statement “Race Relations in My Organization Are Good” By Race/Ethnicity and Presence or Absence of Diversity Initiatives (Percentages)

	Prevalence (all respondents)	Black		Hispanic		Asian	
		In place	Not in place	In place	Not in place	In place	Not in place
Affirmative action plan	65%	60%*	45%	78%	71%	78%	77%
Diversity committee	46%	61%*	46%	74%	75%	79%	73%
A manager responsible for diversity	45%	60%*	47%	72%	77%	75%	78%
Diversity training for managers at least every 3 years	51%	60%*	49%	79%	72%	83%	73%
Diversity evaluations for managers	21%	62%	51%	91%*	73%	80%	75%
Social gatherings for employees	75%	57%	41%	90%*	67%	81%	65%
Affinity groups	34%	64%*	49%	79%	75%	83%	72%
Mentoring programs	54%	57%	50%	81%*	69%	83%	70%
Policy of seeking diversity in candidates considered for hire	53%	61%*	47%	74%	74%	82%*	69%
Strategic or business objective to increase diversity and inclusion	43%	66%	47%	78%	72%	78%	75%
Plan to increase the number of ethnically, culturally and racially diverse executives on the senior leadership team	31%	64%	49%	73%	72%	86%	73%
A portion of executive compensation tied to diversity goals	10%	57%	52%	71%	74%	84%	75%

* Chi-square significant $p < .05$

were more likely to feel race relations in their organizations were good if their employers had a policy of seeking diversity in candidates considered for open and new positions. To help ensure diverse slates of candidates at the senior level, organizations need to factor diversity into their recruitment for positions at all levels.

Increase the diversity of the senior leadership team. The commitment of top leaders was mentioned by a number of survey respondents as being critical to the successful creation of diverse and inclusive organizations. Further, black and Asian respondents were significantly more likely to feel positively about race relations in the workplace in organizations attempting to increase diversity in the senior leadership team. The desire to have healthcare management reflect the populations they serve should apply all the way to the top of the organization.

Offer residency and fellowship programs. Based on the 2014 survey findings, it appears more than half of those who participated in a healthcare management residency were eventually hired by that organization. Even higher proportions of those who took fellowships were hired by the sponsoring organization. Residency and fellowship programs benefit those organizations that offer them; leaders get the opportunity to work with a new executive before making a permanent hiring decision about him or her. Healthcare organizations need to consider offering residency and fellowship opportunities to qualified graduates to assist their launch into careers in healthcare management.

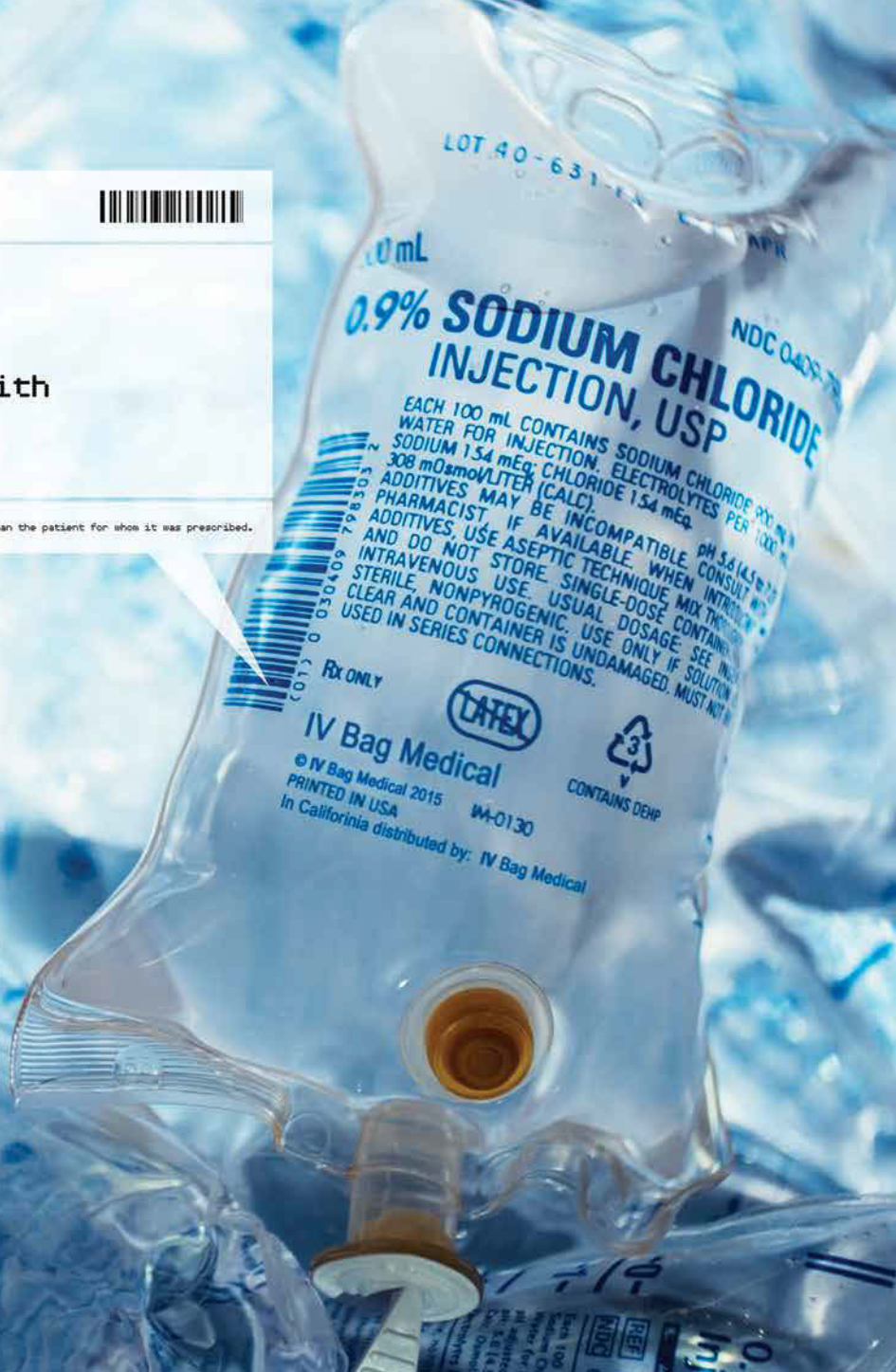
Leslie A. Athey is director of Research for the American College of Healthcare Executives, Chicago (lathey@ache.org).



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Integrated Technologies Improve Medication Management Safety

Bon Secours' medication management platform allows pharmacists to focus on direct patient care while improving patient safety and quality of care.

“By reducing steps and being able to access patient and medication data in one place through the ES platform, we have virtually eliminated variation, which often causes error, and truly improved patient safety.”

— **Jim DeFazio**

Corporate Pharmacy Director
Bon Secours Health System
Marriottsville, Md.

Bon Secours Health System counts itself among those providers that have a clinical pharmacist role at the hospitalized patient bedside. In addition to the nursing and physician staff, pharmacists have joined the system's clinical teams, contributing to improved patient care on patient floors in most of Bon Secours' 19 acute care hospitals.

“Our pharmacists aren't working in isolation in a far-off corner of the hospital,” says Jim DeFazio, corporate pharmacy director, Bon Secours. “They're out on the floors discussing medication therapies with physicians and nurses because we have been able to reduce the amount of busywork from our pharmaceutical distribution processes. We know that our pharmacists' involvement has a direct impact on improved patient outcomes.”

At Bon Secours, pharmacists' enhanced role came as a result of a partnership among the system's pharmacy, nursing and IT staff. This cross-functional team redesigned the health system's medication management processes and workflows that have been impacted by an industry-leading medication management platform. This

collaborative approach has put health network at the leading edge of innovation in its use of automation.

Decreasing Medication Turnaround Time

Seven years ago, Bon Secours initially committed to improving its medication management processes. “Most pharmacists are familiar with the studies showing that a delay in medication therapy puts patients at unnecessary risks and increases length of stay,” DeFazio says. “With that in mind, we wanted to reduce the time between when a physician writes an order for a medication to when that medication is actually administered to the patient.”

The system's first step toward improvement was to install medication cabinets containing 90 percent of the most commonly used medications on nursing floors. Since then, Bon Secours has consistently been reaching its seven-minute turnaround benchmark throughout the system.

But during the time since Bon Secours first implemented decentralized medication management, the healthcare industry has transformed in nearly every arena, from reimbursement provisions to sophisticated IT requirements to hospital system consolidations. System leaders recognized that to face these growing challenges, they needed flexible medication management solutions to provide enterprise-wide capabilities.

“We have 19 acute care hospitals in six different states, each with its own unique culture,” DeFazio says. “We wanted to integrate our pharmacy processes with health information technology across our system for a cohesive approach in the current—and future—healthcare environment.”



CareFusion

has joined BD

Centralizing Control of Medication Management

With the desire to expand enterprisewide capabilities, Bon Secours assembled a cross-functional team that included staff from pharmacy, corporate IT, clinical IT and nursing. "The interconnectedness among departments and hospitals was crucial to moving us forward," DeFazio says. "We wanted this to be a systems approach, not just 19 different subunits pushed together." Using Six Sigma techniques—which many team members had already been trained in—the group examined workflows from all perspectives to ensure the process was truly streamlined and would never require a workaround.

Next, after researching several options and conducting site visits, Bon Secours chose the Pyxis ES platform from CareFusion, a BD company, to help simplify and standardize medication management across the enterprise. The ES platform is interoperable with Bon Secours' pharmacy information system, resulting in a single formulary for the entire organization that can be adjusted as needed for each hospital. This interoperability leverages centralized configuration efforts across the health system.

"The drug database was built just once, and as each hospital comes on board, staff are able to simply pull up the existing, centralized database. The nomenclature is standardized rather than re-created at each site," DeFazio says. "By reducing steps and being able to access patient and medication data in one place through the ES platform, we have eliminated variation, which often causes error, and truly improved patient safety."

Moving Pharmacists Into a Clinical Role

Bon Secours' new platform hosts a Web-accessible server

that enables pharmacists to step out of the central pharmacy and remotely perform patient-care activities from any hospital computer. The ES interface also helps pharmacy staff manage tasks more efficiently. Expanded scanning functionality helps ensure the right medications are loaded into the right system and dispensed for the right patient.

"We have created an environment in which pharmacists, nurses and physicians interact directly. They can discuss alternative therapies and work together to come up with treatment options that enable patients to heal fast," DeFazio says. "It's about making decisions as a well-rounded team at the point of care."

In addition to facilitating a more hands-on role for pharmacists, the ES platform helps nursing staff perform more efficiently and safely. The new system dispenses medication in four steps within five seconds. Safety enhancements, such as clearly highlighting patients with the same last name, help reduce the risk of potentially harmful errors.

With half of the health system fully live on the ES platform and the rest expected to follow by March 2016, Bon Secours has achieved a level of integration that supports centralized control of its medication dispensing systems. At the same time, the platform gives the health system the data it needs when and where it is needed for immediate decision making and reporting.

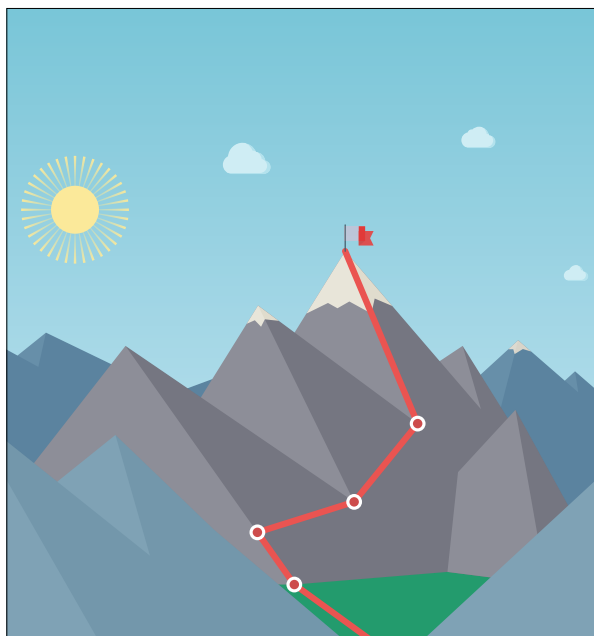
For more information, please contact Jim DeFazio, corporate director, value analysis, Bon Secours, at james_defazio@bshsi.org or (410) 362-3000.

LEADERSHIP

Top Organizations Share Similar Characteristics

According to the Hay Group's "Best Companies for Leadership" study, organizations that are models for leadership excellence take a determined and disciplined approach to helping leaders develop and rise within their organizations. Eighty percent of the top 20 companies had established clear career paths for their employees, compared with only 48 percent of all other companies. Similarly, 80 percent of the top 20 were well ahead of their peer groups in providing career development experiences for their organization's highest-potential talent, ensuring the company has the right people with the right skills when needed to fill their most critical roles.

Not only do the top 20 companies provide clearly defined and varied routes to leadership, they also intentionally seek to develop diverse leaders. Half offer special leadership development programs for women, compared with 13 percent of all other companies, and 40 percent of the top 20 have programs geared toward diverse groups, compared with only 11 percent of all other companies. Top companies also tend to make leadership development programs available at all experience levels (83 percent, compared with 57 percent of other companies). Not surprisingly, the top 20 also are more likely to report



diversity among their senior ranks, with 68 percent (compared with 53 percent of all other companies) indicating the diversity of their senior leaders reflects the diversity of their employees.

Purpose-Built Leaders

At the top 20 companies, flexibility to respond to economic changes was identified as a top challenge for leaders during the next 12 months, along with the ability to capitalize on opportunities within emerging markets. Surprisingly, in an era where organizations are increasingly turning to online learning, the top 20 are leveraging high-touch methods of educating their workforce. Classroom-based leadership training still remains the preferred method among the top 20 firms (used by 74 percent of the top 20 vs. 51 percent of all other companies), with mentoring by senior staff and coaching from internal resources also highly prioritized (69 percent and 61 percent, vs. 41 percent and 34 percent, respectively).

Outstanding companies are recognizing that developing strategic, globally connected leaders for the future means they have to make investments to bring leaders together to learn as a community while using the best technologies to connect people globally and bring learning back to their teams and organizations.

Source: Adapted from an article by the Hay Group. Visit www.haygroup.com/BCL for more on this topic.

*“Management is about arranging and telling.
Leadership is about nurturing and enhancing.”*

—Tom Peters, author, *In Search of Excellence: Lessons From America's Best-Run Companies*



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4 Ways to Support Emerging Physician Leaders

We recently touched on the emergence of physician leaders in the healthcare industry and how their approach to leadership has the potential to clash with the more traditional mindsets and backgrounds of the average senior executive. This phenomenon is called physician whiplash, and it could throw a wrench into a health system's operations if not managed carefully.

Thankfully, the overlaps between senior executives and physician leaders mean there's plenty of common ground to build a respectful co-existence between the two. Supporting physicians in mastering the practice of leadership requires laying out the challenge and committing to physicians who answer the call to lead. If senior teams and boards can make the following statements and follow up with credible sustained actions, they can be confident they are well-positioned to support their emerging physician leaders.

To best demonstrate support in your physician leaders, it is important to communicate the following:

- You understand the challenges they face in practicing both great medicine and great leadership and are committed to helping them overcome those challenges to achieve.
- You will address and work to resolve any barriers that may be obstructing their transition into leadership, particularly for integrating physicians into existing leadership structures.
- You will lend your support and help reduce their learning curves as they take on leadership duties (such as heading up projects) so desired outcomes can be achieved together.
- That you will offer substantial leadership development catered to the physicians' specific needs and roles.

Source: *The O'Brien Group*. Visit www.obriengroup.us.

MANAGEMENT

From Micromanagement to Abdication Management

The following is an excerpt from a blog post by Patrick Lencioni, CEO of The Table Group, a leadership consulting group, and best-selling author of books focused on leadership.

In the past, people who have accused their bosses of micromanaging do so as a permanent insult more than a mere suggestion for change. Micromanagers were assumed to be insecure and distrustful, so no one wanted to have that label applied to them. To make matters worse, being called a micromanager was almost indefensible; if an employee felt he or she was being micromanaged, those feelings needed to be validated and addressed.

It might be tempting to read this and think, "What's the big deal?" Well, there was an unintended consequence that had a negative effect on leaders that continues today. See, the pendulum swung far away from micromanagement and seemed to get stuck on the opposite end of the spectrum, in a place I'll call "abdication management."

Today, for every real micromanager I come across, especially at the top of organizations, there are dozens of abdication managers. These are the people who know little about what their direct reports are working on and defend their approach by citing their own busy schedules—or worse yet, by proudly using words like trust, autonomy and empowerment. Unfortunately, the results of abdication management are consistent: a lack of necessary guidance, delays in recognizing problems, stunted professional development of key people and anxiety among employees. The consequences of abdication management on the bottom line of an organization are not hard to imagine.

Addressing this problem requires understanding its root causes. These include the fear of being accused of micromanagement, negligence and ignorance.

When I've confronted CEOs and senior executives about their tendency to undermanage their direct reports, I've often received an explanation that goes something like this: "Listen, I hire senior people with experience, and I don't think they need me to manage them." This lack of energy for managing people represents one of the biggest problems I see in corporate life. Management of direct reports is too often seen as a remedial activity, reserved for employees without experience, rather than an essential requirement for providing order and clarity for people at every level of an organization. The nature of how people are managed will certainly vary depending on a person's role and level of maturity, but managing them is never optional, and the consequences of neglecting the need for management are always serious.

None of this is to say true micromanagement is a good thing. But I'm convinced most companies would be far better served if their leaders walked a little closer toward the micromanagement end of the spectrum than the abdication end. I've learned this the hard way.

I've noticed when one of the people I'm supposed to manage is working on something that is not particularly interesting to me, I find it easy to say, "I'll trust that person to do what's right." I proudly leave all the details to him

or her and get involved only when a problem arises that actually impacts my world negatively. I'm usually a little grumpy when this happens. Of course, there is nothing virtuous about that.

But when I'm working on a project that is near and dear to my heart, I stay involved in a way that keeps my employees on task, allows me to see potential problems before they get out of hand and provides my staff with a level of confidence that they are headed in the right general direction. Do I occasionally wonder if I'm stepping over the micromanagement line? Yes. And so I wrestle with the tension of being in that place instead of running from it. Consequently, those projects usually go better than the others.

My challenge, and the challenge of every other leader who occasionally participates in abdication management, is to be more consistent in the way I manage and not let my management style be determined by my level of interest, energy or curiosity. That would certainly be a more responsible, intentional and effective approach—one that would benefit my company and the wonderful people who work here.

Source: Adapted from "Micromanagement Is Underrated," *The Table Group*, April 2015. Visit www.tablegroup.com.



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Paul B. Hofmann,
DrPH, FACHE

The Urgent Need for Fatigue Management Policies

Tired staff risk harming patients, themselves and others.

A nurse strikes and kills a cyclist—a father of two young children—while driving home from the hospital after working a double shift. Another healthcare professional falls asleep on the job in a group home; one of her patients dies after receiving insufficient oxygen.

These are two extreme, real-life examples bolstering growing evidence showing that when nurses, physicians and other members of the healthcare team are fatigued, they are more likely to jeopardize others or make a clinical mistake, regardless of their qualifications, compassion and dedication.

A 2013 report, commissioned by Kronos Inc. and conducted by HealthLeaders Media, indicated more than 25 percent of the nurses surveyed said fatigue caused them to make an error at work. The figure may actually be higher because many nurses, physicians and other staff members are likely unaware when fatigue affects their judgment.

Although the issue of healthcare provider work hours and sleep deprivation has been studied for years, healthcare has been slow to enforce policies addressing fatigue.

Increasing Evidence of Need for Action

In the November 2007 issue of The Joint Commission's *Journal on Quality and Patient Safety*, Steven Lockley, PhD, and his colleagues with the Harvard Work Hours, Health and Safety Group provided a comprehensive review of the effects of healthcare provider work hours and sleep deprivation on safety and performance. In its 2007 analysis, the Harvard Group determined that "long work hours increase the risk that nurses and doctors will suffer an occupational injury with potentially devastating long-term consequences and increase the risk of motor vehicle crashes."

They concluded the number of hours worked by U.S. healthcare providers is unsafe.

"To reduce the unacceptably high rate of preventable fatigue-related medical error and injuries among health care workers, the United States must establish and enforce safe work-hour limits," the authors wrote.

In 2010, teaching hospitals were required to place an 80-hour weekly limit on house staff; however, James Bagian, MD, director, healthcare

engineering and patient safety, University of Michigan, said recently he is unaware of any institution that has an effective policy for residents and, in his experience, "The situation is worse for other care providers."

There is much more robust literature on fatigue management in other fields, particularly and predictably in ground and air transportation. For example, in its February 2012 issue, the American College of Occupational and Environmental Medicine's *Journal of Occupational & Environmental Medicine* contained detailed guidance on fatigue risk management.

The ACOEM report highlighted four points regarding the risk of employee fatigue in the 24/7 workplace:

- Fatigue is related to duration of sleep and timing of sleep.
- Inadequate sleep is correlated with a variety of adverse medical outcomes.
- Various shift work schedules can affect both the duration and timing of sleep.
- Inadequate duration of sleep is correlated with injury rates.

Last year, the American Organization of Nurse Executives reported 56 percent of survey respondents said their hospitals disregard required rest periods, and 65 percent said their hospitals do not have policies regarding cumulative days or extended shifts. One hospital with which I work has a 48-hour week work limit and another has a 60-hour limit. Undoubtedly, other hospitals have different limits, but how consistently are these restrictions monitored?

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In addition to fatigue caused by too many hours of work at the hospital, it is increasingly common for hospital employees to have multiple jobs. Hospitals with policies stipulating a limit of 48 hours or 60 hours per week rarely, if ever, take this reality into consideration. Furthermore, in many urban areas where housing is more expensive, longer commutes are increasingly common. Research has verified that driving while tired, like driving under the influence of alcohol or drugs, results in slower reaction times and possible accidents.

As expected, studies also have confirmed sleep and the circadian system also play an important role in cardiovascular health. A 2015 study published in the *American Journal of*

Preventive Medicine involving almost 75,000 U.S. registered nurses and 22 years of data concluded mortality from all causes appeared to be 23 percent higher for women with 15 years or more of rotating night shift work.

Preparing a Meaningful Fatigue Management Policy

It is both organizationally urgent and ethically essential that organizations take a stand on employee fatigue and create a fatigue management policy that promotes both patient and employee safety.

A logical first step in creating a policy is to engage a focus group of nurses and others to begin discussing the issue and solicit ideas and recommendations.

The policy should begin with a concise description of its purpose. By using this introduction to emphasize why the policy is needed, the hospital can explain that patients, staff and the community will benefit by having a clear statement of steps taken to prevent, or at least minimize, fatigue and its adverse outcomes.

The American Nurses Association, representing the interests of the nation's 3.1 million nurses, suggests this policy:

- Limit shift lengths to 12 hours and work weeks to 40 hours.
- Abolish mandatory overtime.
- Promote regular rest breaks.
- Allow nurses to decline assignments they think will cause fatigue.



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- Restrict consecutive night shifts for nurses who work both days and nights.
- Provide nurses with places to sleep or transportation when they feel too tired to drive.

Expecting hospitals to limit the work week to 40 hours, given unpredictable changes in patient census and staffing resources, may be unrealistic, but this doesn't mean hospitals shouldn't review their current practices and establish an appropriate policy.

In assessing its safety culture and staff resilience, Duke University Hospital asks nurses to indicate how often they got less than five hours of sleep in the past week, a threshold below which social and emotional functioning are significantly compromised. Analyzing the data by clinical service unit and comparing changes between survey periods allows leaders to develop and focus their organization's intervention strategies and also helps predict where there are vulnerabilities (e.g., the potential for disruptive behavior and delays in the delivery of care resulting from nurse fatigue).

Just as adult children are hesitant to ask an elderly mother or father to give up their car keys, there are obvious difficulties in enforcing a policy when it may be evident an employee should not be working an extra shift or driving. It is quite likely the employee will reply, "I'm fine and have no problem working a double shift and driving home."

As emphasized in "The Myth of Comprehensive Policies" (*Healthcare Executive*, September/October 2012), even the best policies are meaningless if staff are not educated in their application, compliance is not monitored,

areas of noncompliance are not addressed, and the policy is not periodically reviewed and revised to ensure its continued value.

Preventing even one tragedy affecting a patient, employee or member of the community is worth the investment. ▲

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Neil R. Fedders,
OTR/L

A Model for Change

Change management techniques help enhance the patient experience.

At a time when healthcare leaders have access to an unprecedented amount of data, we are only just beginning to understand how to use it to drive intentional, measurable change. At Mercy Health—Anderson Hospital in Cincinnati, our systemwide approach to using data to identify opportunities that will transform the patient experience over the past three years has reduced ED door-to-provider and treatment-to-release times and left-without-being-seen rates, increased collaboration between EDs and inpatient units and enhanced patient satisfaction.

Linking Data With Process Improvement

In 2009, Mercy Health—the largest health system in Ohio and one of the largest nonprofit health systems in the United States, serving communities in Ohio and Kentucky—faced challenges related to ED crowding and boarding as well as around efforts to develop a more patient-centered culture.

When it came to patient experience, data suggested the performance of Anderson Hospital, a 190-bed hospital with 1,000 inpatient admissions and 3,500 ED visits per month, was mediocre, although its quality outcome measures were and continue to be ranked among the best in the country, and its financial performance was

strong. For example, in the first quarter of 2015, Anderson Hospital was recognized by Truven Analytics as one of the country's 100 Top Hospitals for the 10th time, and the hospital has been rated by Truven as one of the 50 Top Cardiovascular Hospitals in the nation. But the data captured through patient satisfaction surveys indicated the hospital was not delivering a fully desirable patient experience.

In 2010, Mercy Health began to focus systemwide on improving operational efficiency, and in 2012, leaders and staff began concentrating efforts on improving the patient experience. In its EDs, the health system's goal was to achieve top-quartile performance on patient satisfaction surveys in the category of ED overall rating.

Mercy Health's ED Transformation Committee led improvements in front-end processes, patient flow, communication and culture that resulted in demonstrable increases in patient satisfaction, as seen in the exhibit. By 2013, 86 percent of Mercy Health EDs were performing as well or better than their national peers in the category of ED length of stay, and all of the health system's EDs had decreased the average door-to-provider time to 30 minutes or less. But Anderson

Hospital continued to struggle with its performance. The average ED length of stay was 395 minutes, and the overall rating of care provided by the ED fell in the 63rd percentile. There were opportunities to improve communication around medications prescribed to patients and discharge instructions.

In 2013, leaders at Anderson Hospital decided to implement a model for change management in the ED and throughout the hospital, using the Institute for Healthcare Improvement's small-test-of-change guidelines:

- Use Plan-Do-Study-Act to test ideas for change on a small scale to determine whether they result in improvements.
- If improvements are recorded, expand the tests gradually until you are confident the changes should be more widely adopted.

In April 2013, team members at Anderson Hospital performed a kaizen event that enabled staff to identify opportunities to improve ED throughput, discharge for acute care patients, communication around medications and room turnaround times. The team also identified change-management metrics that could be monitored to determine the impact of the hospital's efforts.

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Using Change Management to Guide Improvement

Anderson Hospital began testing ideas for improving patient discharge. Staff developed a discharge checklist to make the process more patient centered, ensuring patients know who their discharge planner is and understand their plans for care after leaving the hospital and what medications to take; symptoms and side effects to watch for; and when to receive follow-up care, with follow-up appointments made prior to leaving the hospital.

In June 2013, an inpatient unit piloted the discharge checklist to gauge its effect on supporting an enhanced patient-centered discharge process. Based on the immediate improvements recorded, teams on several acute care floors soon implemented the checklist, and by August 2013, the checklist was applied hospitalwide. Since the checklist was implemented, Anderson Hospital has performed at or above the top quartile in patient satisfaction related to the discharge process, with monthly top box scores as high as 91.5 percent in this domain.

We also take a measured and intentional stance in monitoring the success of the initiatives we have implemented on a weekly basis, knowing patient satisfaction scores do not become available until four to six weeks post discharge. Nurse managers complete weekly audit forms for our senior leadership team to review, providing feedback on follow-through for frontline initiatives, the successes and challenges related to implementation of such initiatives and feedback that could help other units in their efforts. The audits enable senior leaders to view—in near-real time—progress made in specific areas and to spot opportunities to share best practices in one unit with the team as a whole so successes could be achieved systemwide.

Nurses also began to accompany physicians during rounding. As part of this initiative, a physician will notify a nurse when he or she is ready to see a patient in an inpatient unit. Anderson Hospital's EHR features a treatment team column that identifies the nurse whom the physician should contact and the nurse's phone number. Together, the physician and nurse discuss the patient's treatment plan

with the patient and family members, where appropriate, and answer questions regarding the patient's care. So far, results for this initiative have varied, primarily due to inconsistent application of this approach. While scores that rate patients' communication with their physician have steadily increased since the first quarter of 2014, exceeding top-quartile performance in the third quarter of 2014, scores dipped below top-quartile performance in the fourth quarter of 2014.

Anderson Hospital's medication side-effect initiative also experienced top-quartile success in 2014. When a patient is placed on a new medication, a nurse will place an "M" on the whiteboard in the patient's room. The "M" reminds nurses to review possible side effects of the new medication with the patient during each shift and prompts the administrative ambassador to provide one-on-one instruction on why the medication was prescribed and side effects to watch for. In just three months—from the first quarter of 2013 to the second quarter—scores for communication about medications rose more than 5 percent, from 61.2 percent to 66.4 percent. Last year, Anderson Hospital achieved top-quartile performance in this area during all but one quarter.

Administrative discharge rounding—in which members of Anderson Hospital's management team visit with patients on inpatient units daily—is another initiative in which Anderson Hospital experienced top-quartile success last year, improving scores in the category of overall rating

Patient Satisfaction at Mercy Health–Anderson Hospital

Top Box Scores for Domain	2010	2011	2012	2013	2014
Overall rating of care	63.4	68	69.7	73	74.1
Communication with RN	74.2	78	80.5	81.6	81.8
Communication with MD	74.6	76	77.9	78.8	80.8
Pain control	67	70	72	73.4	73.9
Explain medications	56	60	62	64.3	64.8
Discharge instruction	79	81	84.9	86.5	89.5

Source: Mercy Health–Anderson Hospital, based on data collected from Press Ganey surveys.

of care. Each day, members of the management team are assigned several rooms to round on. During rounds, hospital leaders seek real-time feedback on the quality of care and provided services and look for opportunities to resolve issues, if any, and to recognize staff who have delivered on our promise and provided an outstanding experience. Administrative discharge rounding also allows for teach-back moments for staff, communication with family members and nurses, and establishment of a stronger connection with patients.

Lessons Learned

Measuring change—especially as it impacts the patient experience—can be tedious, as it can take three months to demonstrate measurable improvement and determine how to sustain and build upon successes. When weekly patient experience score updates are posted for staff to see—as they are for each site and each inpatient unit throughout Mercy Health—it can be difficult for staff who are in the midst of a change initiative not to see the results of their efforts reflected in their unit’s scores for some time.

That’s why the small-test-of-change process works particularly well with initiatives designed to improve the patient experience: Front-line staff are encouraged to make tweaks to new processes as they are rolled out on a small scale until they feel comfortable with the processes. This results in processes that staff not only use, but also believe in.

Overcoming cultural barriers—which can exist from unit to unit and, at times, from department to department—also is critical. Unit managers

must believe in the change management process. The message these managers send to their teams during each huddle and staff meeting regarding the importance of a new initiative must be consistent, particularly if the patient experience scores recorded in the early weeks or months of an initiative are less than desirable.

It’s also important that managers and staff understand gains in performance improvement can be seasonal. It is relatively easy to apply, track and measure initiatives when hospital volumes are optimal. It can be difficult to apply new processes consistently when volumes are very high. When leaders encourage their teams to be patient and focus on the big

picture—and when they demonstrate patience with the initiative as well and share positive, real-time feedback received through efforts such as administrative rounding—teams will be more likely to believe their efforts have the potential to effect measurable change that makes a difference for those they serve. ▲

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The author would like to thank Denise Irizarry, RN, DNP, CPHQ, CEN, system director, patient safety and clinical transformation, for her contributions to this article.

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Stephen L. Mansfield, PhD, FACHE



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Mike Tinney

Improving the Health of Patient-Care Staff

A Texas hospital network partnered with a wellness company to increase activity.

Nurses are dedicated to providing patient care, but irregular hours, job stress and being on their feet all day can cause them to neglect their own health. According to a University of Maryland study, 55 percent of nurses are overweight or obese. In December 2014, Dallas-based Methodist Health System, a network of hospitals, sought to increase the activity levels of its staff in a way that was enticing and easy and didn't interfere with their ability to provide top-notch attention and treatment to their patients.

Methodist Health System found its ideal wellness partner in Fitness Interactive Experience, an Atlanta-based company that creates high-quality, interactive games to promote health and daily activity in an exciting, socially connected environment. A 20-plus year veteran of the video-game industry, Mike Tinney, CEO, FIX, applies his expertise in incentive and reward mechanisms to encourage users to enhance their exercise, nutrition and overall health.

Methodist signed up for a six-week challenge using FIX's flagship product, UtiliFIT, which sends an hourly email or text reminder to complete a low-impact but effective exercise

that takes less than two minutes. These reminders included photographs that demonstrate how to do each exercise, including chair squats, desk pushups and simply walking up a flight of stairs. The exercises were tailored to each participant's level of fitness and became increasingly difficult as the challenge progressed. Participants had an hour to complete each exercise so as not to disrupt their patient interaction.

An Overwhelmingly Positive Response

Following FIX's advice, Methodist Health System made the challenge completely voluntary for employees. In planning the challenge pilot, the health system aimed for 100 registrations; it experienced such a favorable response that it expanded enrollment acceptance to nearly 500 employees. Eighty-seven percent of those who signed up for the challenge completed it, and 75 percent participated every day.

Employees' response to the activity was exceedingly positive, and the results were even better than anticipated. Of the three activity components, 100 percent of employees participated in the fitness program, 63 percent completed everything prescribed for nutrition and 45 percent

participated in all of the lifestyle changes, which included drinking eight glasses of water a day, getting seven hours of sleep a night and turning off electronic devices an hour before bedtime.

Employees appreciated how flexible the challenge was: Although most participated in it during their shifts, they could start and stop at any time, giving them the ability to participate after their shifts or during days off. A few employees even encouraged family members to participate. After the six-week challenge was over, many employees continued to replicate it on their own.

Overall, the challenge was a huge success, garnering even higher engagement rates than either FIX or Methodist Health System anticipated. It complemented and added a layer of fun to the hospital network's existing wellness program, which relies on quantitative measurements such as biometric screenings. Later

This column is made possible in part by Trane Healthcare.



this year, Methodist plans to implement another one of FIX's challenges, which focuses on increasing the number of steps participants take per day.

The Four Cornerstones of Wellness

At the beginning of its engagement with Methodist Health System, FIX outlined what it calls the four cornerstones of wellness, which are the components of a corporate wellness program that can significantly increase participation in voluntary challenges and other initiatives. These cornerstones can be implemented by any hospital or healthcare organization regardless of its number of employees, wellness budget or other factors.

- **A track record and established history of wellness.** Wellness initiatives are a cumulative process. The more positive wellness events a company offers, the more participation will grow over time. Similarly, healthcare executives working with a wellness vendor should be wary if the organization promises a certain engagement rate without asking any questions specific to the organization.
- **Rewards and recognition to employees who participate in wellness initiatives.** Incentives can encourage staff to complete a wellness programs—whether it be public recognition, meaningful rewards, benefits or all of the above depends on the company and its culture. A financial incentive to participate—like a paid day off, a lunch provided by the company or a gift card—has a

high potential to drive engagement. Methodist provided employees with a \$20 bonus per paycheck. Nonmonetary rewards also yield participation. These can include a mention in the company newsletter or a callout by the CEO during a company-wide meeting.

- **Leading from the front.** The CEO can have a huge influence on employees with regard to a wellness program. When an organization's leadership is visibly involved in programs the staff is asked to do, engagement rises. When CEOs and other executives participate in wellness programs, this sends a message that it's an important part of the company, and it should become part of the corporate culture. Even having the C-suite do a variant of the program, perhaps with fewer time commitments, can be a powerful way to encourage participation.

To increase success of the wellness program, Stephen Mansfield, PhD, FACHE, president/CEO, Methodist Health System, headed an initiative asking all leaders to complete a health coaching session for its personal benefit and inspire staff participation. The leadership team demonstrated its own commitment by joining and leading teams and not reducing its own participation levels.

- **Teammates and opponents.** A University of Michigan study found people who exercise with a partner put forth twice the

energy and effort than people who exercise alone, and people who exercise on a team put forth three times the energy. UtiliFIT used a points system for completing hourly fitness activities, exercising and making positive nutrition and lifestyle choices. A leaderboard added a healthy dose of competition to the challenge.

An upcoming FIX challenge Methodist plans to implement takes the idea of friendly competition even further by creating teams that will be pitted against each other. This can have a huge psychological impact when it comes to pushing ourselves physically, as people are more likely to follow through when others depend on them.

The bottom line is that hospitals and other healthcare organizations must recognize that just because their employees are committed to improving the health of their patients doesn't mean they're paying the same attention to their own health and well-being. By adopting wellness initiatives that are engaging and easy to partake in, healthcare executives can overcome many of the obstacles nurses and other patient-care staff encounter when it comes to maintaining a healthy lifestyle. ▲

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Daniel B.
McLaughlin

What's Next for Healthcare Reform?

A close look at reform agenda setting provides hints to future policy.

From the time ship owners were levied a tax in 1798 to pay for seamen's healthcare and in almost every year since, the federal government has enacted healthcare reforms. The most recent example is the 2015 legislation to finally reform physician payment under Medicare. If healthcare reform is a journey and not a destination, what can we look for in the future?

To anticipate future health policy, it is most useful to focus on the public agenda setting that is occurring today. Once an agenda is set, it can be translated into policy, enacted and then implemented. Agenda setting has three major components, and they were very apparent in the Affordable Care Act legislative process:

- **A need to act is widely perceived by policymakers.** The ACA health exchanges and Medicaid expansion dealt with the growing number of uninsured.
- **Policy options are available that have been shown to work.** Many of the ACA's features, such as accountable care organizations and bundled payments, were based on

Medicare demonstration projects that had favorable results.

- **A wide array of constituencies can support legislation.** Many of the major healthcare trade associations supported (and authored) much of the ACA. Although the ACA as a whole was strongly opposed in a political manner, most of the policy issues within the law continue to have both health professional and public support.

Four major institutions are engines in the policy process and regularly develop policy initiatives that meet the three criteria to be part of the agenda-setting process. The Patient-Centered Outcomes Research Institute and the Medicare Innovations Center advance improvements in healthcare delivery, while the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission devise actual policy options for existing problems in the system. The work of each of these groups could have implications for public policy.

Patient-Centered Outcomes Research Institute

The PCORI was created as part of the ACA as a separate nonprofit

whose goal is to "close the gaps in evidence needed to improve key health outcomes." It has four major research priorities, which include assessment of prevention, diagnosis and treatment options; communication and dissemination research; addressing disparities; and accelerating improvements in research methods.

To anticipate future health policy, it is most useful to focus on the agenda setting that is occurring today.

The institute's fifth priority is of particular interest to those trying to discern future healthcare policies: "improving healthcare systems: comparing health system-level approaches to improving access, supporting patient self-care, innovative use of health information technology, coordinating care for complex conditions and deploying workforce effectively."

PCORI has many interesting projects underway in this domain. For example, one project involves working with stroke survivors and their caregivers to develop an effective smartphone app, which would continuously monitor health measures, stay current with a constantly changing list of medications and appointments, and encourage the patient to keep up his or her exercise program. Future policy implications for this project include clinical data interoperability,

provider and caregiver roles, and payment systems.

PCORI has funded 65 projects in this area.

Medicare Innovations Center

The Medicare Innovations Center also was created in the ACA and has a mandate to test new innovations in care delivery in these areas:

- Accountable care
- Bundled payments for care improvement
- Primary care transformation
- Initiatives Focused on the Medicaid and CHIP population
- Initiatives focused on the Medicare-Medicaid enrollees (dual eligible)
- Initiatives to speed the adoption of best practices
- Initiatives to accelerate the development and testing of new payment and service delivery models

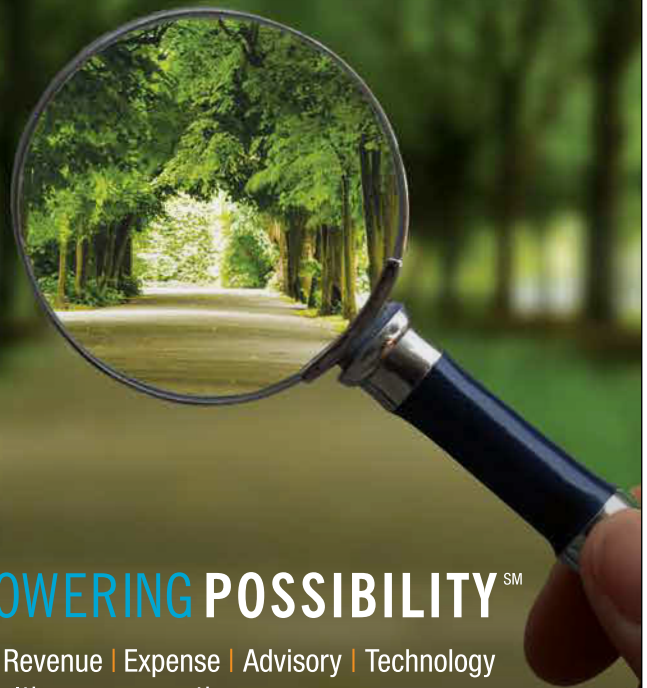
An interesting example from a primary care transformation group is the Comprehensive Primary Care Initiative. Its aims are to see whether primary care practices in a predominantly fee-for-service model can be adequately supported by monthly care management fees and net savings in the Medicare program. If successful, this initiative will provide a policy choice that could allow primary care providers to remain independent rather than

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be acquired by integrated health-care systems.

The Medicare Innovation Center has 61 projects underway.

MACPAC

The Medicaid and CHIP Payment and Access Commission is a federal agency that provides policy and data analysis and makes recommendations to Congress, the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and CHIP. Each year, it produces a report to Congress with analysis and recommended policy changes. Because Medicaid and CHIP are state-administered programs, MACPAC's recommendations tend to be at the broad policy level.

This year's report provides an interesting analysis on premium support that may foreshadow future national policies. The use of Medicaid funds to purchase private market plans (premium support) is one way states may expand coverage to previously ineligible, low-income adults. Arkansas and Iowa have been using premium assistance to purchase plans on the exchange through waivers since January 2014, and other states have expressed interest in this approach. Because Medicaid has historically provided many wraparound services, access to these services is unclear. Also, increased cost sharing in these plans may restrict enrollment and use. However, many state legislators want to expand access using the private sector as opposed to the ACA Medicaid expansion option, and therefore premium support may expand to other states.

MedPAC

The Medicare Payment Advisory Commission was established in 1997 to advise Congress on Medicare. Each year it publishes a comprehensive report with multiple policy recommendations across the entire Medicare program. Most of the recommendations this year are to improve further implementation of ACA policies such as value purchasing and bundling.

However, the success of the Medicare Advantage program is one of the highlights of this year's report. Between 2013 and 2014, enrollment in Medicare Advantage plans grew by about 9 percent (or 1.3 million enrollees) to 15.8 million enrollees. About 30 percent of all Medicare beneficiaries were enrolled in Medicare Advantage plans in 2014. Ninety-one percent of enrollment was in plans with a positive margin, averaging 4.9 percent in 2012.

During the ACA debate, Medicare Advantage was targeted for reductions in payment. In spite of these reductions, Medicare Advantage plans have thrived and now provide a possible pathway for ACOs to move into the Medicare Advantage world with more predictable market shares and margins.

Trends Not Yet in the Pipeline

Because all four agencies have complex governmental processes they must undertake before initiating projects, they are not necessarily engaged with emerging trends. Innovative health systems are sponsoring pilots that may become projects within PCORI or the

Medicare Innovations Center, which would then embark on the road to becoming part of national health policy. Some examples:

- Care delivery changes prompted by innovations in primary care, new provider types, telemedicine, home automation wearable technologies and the Internet of Things
- Precision medicine—a more individualized approach to medical decision making, treatment and more—is explored even as the increasing cost of care remains a national concern
- HIT effectiveness increases dramatically—but so do related security and privacy concerns
- Narrow networks expand, but access concerns grow
- Mergers and acquisitions continue, presenting growing anti-trust challenges

Planning for Future Health Policy

Each of the four federal agencies provides excellent online reporting and resources. Healthcare delivery organizations will benefit from periodically reviewing their reports to determine which demonstrations and experiments may become health policy and how they may affect their organization's strategic plans. ▲

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J. Craig Honaman,
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Coaching Emerging Healthcare Leaders

Sharing lessons learned is critical to the future of healthcare leadership.

Developing and molding future senior healthcare leaders is integral to ensuring the continued success of the healthcare field. Making time for mentoring should be a priority for healthcare's senior leaders, both for the good of their organization and the industry as a whole.

Networking and interacting with people effectively in a business environment is a lifetime essential career skill.

Coaching emerging healthcare leaders is a simple task. It's even easier for those senior executives who received coaching themselves and made a record of advice they received: They are primed to share their lessons learned with younger careerists based on their experience with senior coaches. Below are 11 successful ideas and best practices in leadership to share with emerging leaders.

Tips for Success in Mentoring Early Careerists

Think long term. The ways in which senior executives moved up in their career may not be transferable to today's healthcare environment, and jobs early careerists are searching for today might call for different skills

three to five years from now. Identifying the lasting skills needed for a successful career will go a long way in ensuring job attainment for up-and-coming leaders.

Encourage participation in entrepreneurial events. Such events are wonderful teaching tools that enable early careerists to experiment with creativity and risk while finding new avenues for success. An executive must be able to demonstrate performance and personal worth to the company every day to ensure ongoing success—not just when there is an impending annual performance evaluation. Teaching early careerists the value of going for the extraordinary in all they do will position them for success. Thinking outside of the box by trying new ventures can be a starting point.

Be ready to tell your story of handling difficult situations successfully. The sharing of both successful and unsuccessful events that have occurred throughout a senior leader's career can be learning tools for early careerists, who will gain insight on what to do when faced with a particular issue. By understanding what other senior executives have gone through, the early careerist's own learning curve can be enhanced.

Share tips for effective communication skills—written, verbal, visual and listening. With the prevalence of smart devices, emerging leaders from the millennial generation and those who are younger often spend a vast amount of time looking down at their devices instead of paying attention to the world around them. Teaching emerging leaders the importance of looking someone in the eye instead of focusing on an electronic device can be an immensely powerful lesson. Social media also can contribute to the erosion of communication skills. On many sites, users may not be communicating in full sentences. Becoming accustomed to this shortcut writing style can hurt an early careerist when trying to write a position paper, a business plan or a business letter. To be taken seriously, early careerists must be prepared to deliver messages more formally, using proper grammar and conventional business style. Coaching emerging leaders on the communication skills needed to succeed in the business setting can set these young executives leaps and bounds ahead of their peers.

Support early careerists in joining a professional group. Membership in a professional organization such as ACHE advances early careerists' knowledge of current healthcare trends and also provides them with the opportunity to network with colleagues. It gives them a chance to meet others in the field who can

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Jaquetta Clemons, DrPH, FACHE, Fund Scholarship Recipient
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either serve as coaches or assist them in a job search further down the line.

Stress the importance of lifelong learning. School is always in session in the healthcare field. Giving emerging leaders the chance to attend seminars and ACHE programs can help further their career by gathering current

information for use in the workplace. Interaction throughout their career is important—even when they have become senior executives themselves.

Encourage emerging leaders to measure their success in quantifiable terms. One way early careerists can quantify their value to an

employer is delivering twice their salary toward the company's bottom line every year. It may sound intimidating, but it is possible and important: Demonstrating measurable value to the employer may enhance career growth potential within the organization or show value to a prospective employer.

Teach early careerists how to network effectively. Networking and interacting with people effectively in a business environment is an essential lifetime career skill. Help introduce your young executive to peers from outside the organization—connecting with individuals outside their company who may have fresh ideas can prompt emerging leaders to bring those concepts back to their organization. Helping establish a process for emerging leaders to keep track of names, addresses, phone numbers, email addresses and websites so the information can be retrieved easily when needed can be an invaluable skill. The connections and ideas that are gained can be used in day-to-day work or during a job search, when early careerists are looking to stand out from the wide range of applicants during the interview process.

Understand the idiosyncrasies of emerging leaders. For example, physicians are more apt to buy into lessons that can be backed up with numbers, so use statistical data when coaching them. On the other hand, those who are on an administrative track may want to learn more of the business rationale behind a suggested approach. Offering tips to the emerging leader on how best to get their message heard and understood by different groups can enhance their success. Understanding the way in which



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various types of people prefer to learn can enhance the coaching process.

Stress the importance of agility in leadership. As the healthcare field undergoes transformative change, some healthcare positions are expanding with newly defined responsibilities, while others are being eliminated, never to return. New positions also are continually in the works. Senior executives should teach emerging leaders how to successfully adapt to and lead in an era of change. For example, senior executives can help emerging leaders navigate an era of reform by sharing the changes they witnessed in healthcare while moving up in their careers.

Look for opportunities to identify early careerists who may be in need

of a mentor but might not yet know it. Major shifts in the industry can make it difficult to find a healthcare coach today because of short tenure in executive positions. In the past, the average executive tended to remain in a position for 10 or 15 years. Once stable and comfortable in his or her position, the executive typically began to offer advice and information to the emerging leaders within the organization. Today, senior executives are moving much more rapidly into new positions. As a result, they may struggle to find the time to coach early careerists as they become established in their own careers. It is important senior executives carve out time to provide emerging leaders with the knowledge, experiences and career-growth advice only veteran executives can provide.

Planning for the Future

Senior executives who are willing to mentor the emerging leader will establish the effort as a priority and make time for coaching among the members of their executive team. The return on the human investment can be substantial for an organization, its senior executives and its emerging leaders. Early careerists who are taught the skills needed to succeed as leaders from the beginning of their careers will be better able to help guide their organizations and the industry when called upon to make a difference. ▲

J. Craig Honaman, FACHE, CRC, is principal of H & H Consulting Partners (careerdir1@aol.com), Atlanta.

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Governance Principles for Physician Organizations

Healthcare executive support can influence the value these organizations provide.

“A strong, consistent governance and leadership focus on doing what’s best for patients and communities is positioning physician organizations as significant drivers of improved quality and financial performance and as architects of the new care delivery system.”

This is one of the key findings of a recently released report, *Governance of Physician Organizations: An Essential Step to Care Integration*. The report shares results of a study conducted by the American Hospital Association’s Center for Healthcare Governance and Physician Leadership Forum.

The study notes the wide range in organizational size, structure, ownership and control, geographic location and governance structure and practices among participating organizations. It concludes that best governance practices now accepted in hospitals and health systems may not apply in the same way to physician organizations and that there is value in matching governance practices to organizational needs at various stages of their development.

Taking a Closer Look

In the study, AHA defines physician organizations as entities designed to engage physicians in leadership,

governance and decision making of the clinical enterprise. It is among the first to explore governance and leadership in these organizations from the perspective of physicians and the executives who govern them.

Best governance practices now accepted in hospitals and health systems may not apply in the same way to physician organizations.

For the study, AHA interviewed board members and executives from six diverse organizations (see the sidebar). An expert panel synthesized findings to help other physician organizations better understand governance and leadership practices in these evolving entities.

According to the study, there are 10 principles of strong governance that physician organizations can apply throughout their development.

Principle No. 1: Governance becomes more robust and mature as organizations grow and develop.

For example, the processes physician organizations use to select board members, make decisions or evaluate

their performance are likely to expand and strengthen as these organizations become firmly established and continue to broaden their focus outward toward the communities they serve.

Principle No. 2: No single evolutionary path or model of governance will work in all organizations and care systems.

The study notes clinical enterprise boards, enhanced community boards and smaller, high-performing boards that typically provide system-level oversight of strategy, risk and performance can all play roles and already are functioning in many markets.

Principle No. 3: A relentless focus on mission—providing high-quality, safe care for patients—brings clarity and impact to governance structure and function.

Study participants share examples of defining moments in governance—such as requiring adoption of electronic medical records or adding primary care physicians to the board and leadership—that led to higher levels of board and organizational performance with broader impact.

Principle No. 4: Boards should adopt a competency-based approach to member selection, board member

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and leader development, performance evaluation and board decision making. For example, in addition to drawing on leaders of local medical groups or physician-hospital organizations to serve on the boards of physician organizations that are part of health systems, several study participants are beginning to look for specific competencies, such as business, financial or legal skills, as they add new members to their boards.

There is value in matching governance practices to organizational needs at various stages of physician organization development.

Principle No. 5: Boards should seek and balance diverse member competencies to ensure necessary perspectives are present at all levels of governance to meet the needs of patients the organization serves. The skills and competencies needed to govern a clinical enterprise, for example, may differ in some ways from those needed to govern a health system, and member competencies should be matched

with each board’s roles and responsibilities.

Principle No. 6: A robust board culture incorporates discussion, debate and dissenting opinions. Advance preparation, intellectual rigor and continuous learning are expected for participation in governance.

Principle No. 7: Boards can lead their organizations to higher levels of performance. Making and enforcing tough, data-driven decisions and responding productively to defining moments are steps boards can take to set the tone and direction for ongoing performance improvement.

Principle No. 8: When clinicians, outside experts and stakeholders govern collaboratively, the outcomes are more robust and sustainable. One physician organization executive and panelist noted adding an outsider to the board changed the tone of the board’s conversations from representing constituencies to what was in the best interest of the organization as a whole.

Principle No. 9: Formal, rigorous development, performance evaluation and succession for physicians in

leadership and governance roles are essential for their meaningful participation in the transformation of healthcare. Study participants all cited the importance of ongoing governance education, and some have established a governance and leadership curriculum to support continuous learning.

Principle No. 10: Effective boards have credibility with the stakeholders they serve. Leading the charge on quality and safety improvement for the broader health-care organizations of which they are part, or making the decision to participate in Medicaid managed care because “It was the right thing to do” are examples of how physician organization boards and leaders are focusing on improving care and outcomes for the patients and communities they serve.

Action Steps for Healthcare Leaders

CEOs and executives can encourage boards and leaders of physician organizations that are part of their hospitals or systems to assess how their own governance practices compare with these principles. Questions to guide such an assessment are included throughout the report.

Additional findings from the study also can help hospital and health system CEOs and senior leaders further consider how best to support and continue to advance the governance of physician organizations:

The strong focus physician organizations have on doing what’s best for patients and communities is positioning them as key drivers of improved

Study Organizations

Board members and senior executives with these organizations participated in the AHA study:

- Advocate Physician Partners, Downers Grove, Ill.
- Billings (Mont.) Clinic
- East Bay Physicians Medical Group, Lafayette, Calif.
- Hill Physicians Medical Group, San Ramon, Calif.
- Hospital Sisters Health System Medical Group, Springfield, Ill.
- Memorial Hermann Physician Network, Houston

quality and financial performance and as architects of the new care delivery system. By supporting the innovative work physician organizations are doing to create new models of care, hospital and system executives can positively influence the value these models can deliver for patients and communities.

Physician organizations and their governance are still evolving, and the boards of these organizations are growing into their roles. Governance practices will likely evolve to meet the needs of these organizations at various stages of their development.

The evolution of physician organizations may indicate the need for

variation in governance practices from those considered most appropriate for hospitals and health systems today. For example, a blend of representational and competency-based board-member selection processes may work best for some physician organizations during their formation and at other key stages in their development.

If empowered and encouraged, physicians can play a significant role in transforming healthcare and will step up and partner with executives to bring value to the change process.

Investing in physician organization governance is essential to ensure success. For more information about

the study and its findings, visit www.americangovernance.com. ▲



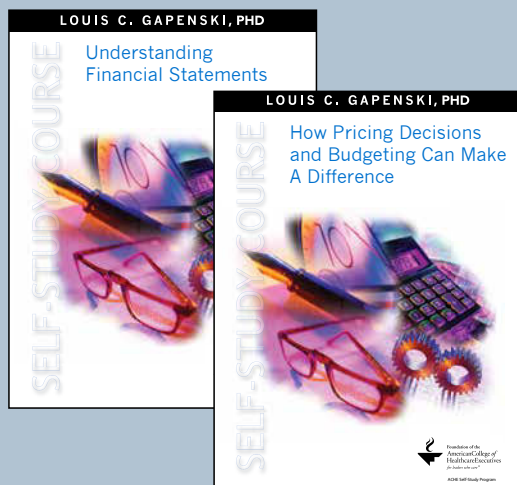
Combes

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Totten

Editor's note: This article was adapted with permission from "Leaders in Transforming Care," published in the April 2015 *Trustee* magazine.



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Assessing Community Health Needs

Assessments are an opportunity to catalyze population health improvement.

The IRS now requires nonprofit hospitals in the United States to complete a community health needs assessment—which includes a description of the community served, existing healthcare resources and a prioritization of the community’s health needs—at least once every three years. These hospitals also are required to develop and execute an implementation strategy for meeting the needs identified in the assessment. At the same time, the Public Health Accreditation Board—a voluntary, national public health department accreditation program supporting state, local, territorial and tribal health departments—requires health departments to complete a collaborative community health assessment every five years and to use the assessment to develop a community health improvement plan.

These requirements provide an unprecedented opportunity for health systems, public health departments and community-based organizations to work together to produce one comprehensive community assessment, coordinate planning and leverage such plans to improve population health.

Taking a Closer Look

For years, the IRS has required nonprofit hospitals to provide measurable benefits to the communities

they serve. These have traditionally been allocated toward uncompensated or underfunded care provided by nonprofit hospitals. In a 2013 study in *The New England Journal of Medicine*, Gary Young, MD, and colleagues found that in 2009, community benefit comprised 7.5 percent of nonprofit hospitals’ operating expenses, with 85 percent of spending focused on uncompensated and underfunded care. Only about 5 percent of the total community benefit provided fell under “community health improvements” undertaken by the hospital itself.

A majority of community health needs assessments completed in the first round of required reporting in 2012 focused on service capacity issues such as access to healthcare services and the provision of clinical care. In a 2014 survey of 51 hospitals conducted by the Public Health Institute, 73 percent of community health needs assessments in 15 regions identified priorities related to clinical care. A 2014 survey of more than 300 nonprofit hospitals conducted by the Health Research & Educational Trust found the most commonly identified driver of community health needs was a lack of access to care (67 percent), and a 2014 survey

of members of the Catholic Health Association, VHA Inc., and the Association of American Medical Colleges found 93 percent of member hospitals prioritized access to clinical care in their community health needs assessments.

A hospital’s community benefit office can be a champion for the transition to population health management.

Logically, hospitals prioritize needs that capitalize on their strengths (e.g., providing clinical care). But to make a bigger impact on population health, nonprofit hospitals must move away from prioritizing service needs in favor of working collaboratively with community organizations to address issues such as obesity and behavioral health. These population health challenges require new kinds of strategies and support to help individuals make healthier decisions, targeting those populations at highest risk for such issues and, as a community, recognizing the impact and beginning to address the socioeconomic disparities that negatively impact health and healthcare.

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As the new business imperative for many hospitals becomes population management, leaders are increasingly realizing their organizations cannot tackle this important work alone.

Fortunately, they don't have to.

Hospitals, public health departments, and community-based organizations are partnering and collaborating in communities around the country to improve community health.

Examining the community data available through the community health needs assessment process helps hospital leaders understand population health management is not just about risk stratification by providing insight into the ways that clinical outcomes are inextricably linked to social determinants of health. (See the sidebar below.)

Getting There From Here

Here are four practical ways hospital leaders can improve the linkage

between the community health needs assessment process, community benefit spending and efforts to improve population health in the communities they serve.

Conduct a community health needs assessment that effectively captures the community's assets and prioritizes health needs. Hospital leaders and community partners should be active participants in conducting the community health needs assessment. There is a plethora of available resources for hospitals, and engaging leaders and staff in reviewing the data and even in doing stakeholder interviews themselves can be illuminating for all involved. An effective community health needs assessment must clearly define *community* and identify the varying needs of both geographic areas and subpopulations to guide priority setting. Hospitals should consider their population

service area (e.g., the geographic area they serve) rather than their market service area (e.g., where most of their patients live).

Hospital leaders also should engage community representatives in all stages of assessment, planning and execution. Although 75 percent of hospitals in the 2014 Public Health Institute survey received direct input from community members in the community health needs assessment process, community stakeholder engagement decreased significantly during priority setting, program planning and implementation. The community health needs identified through the assessment should regularly be brought back to community members for validation. Finally, a community health needs assessment should employ a mixed-methods approach, with quantitative data from multiple sources and qualitative data collected through conversations with community leaders and members outside of health care, such as elected officials, school representatives and social services.

Increase collaboration between multiple hospitals, public health departments and community organizations in a geographic area.

Duplicative community health improvement efforts are common; through better alignment of efforts, duplication could be avoided, and the impact on community health could be heightened. Successful partnerships require formal documentation of commitment (e.g., memorandum of understanding) through which all partners agree on how they want to proceed on both the assessment and implementation

Resources for Community Data

- Commonwealth Fund's Health Systems Data Center, datacenter.commonwealthfund.org
- National Center for Health Statistics' Health Indicators Warehouse, www.healthindicators.gov
- Dartmouth Atlas, www.dartmouthatlas.org
- Dignity Health's Community Need Index, www.dignityhealth.org/Who_We_Are/Community_Health
- Geographic Information System mapping tools
- CDC Community Health Improvement Navigator, www.cdc.gov/CHInav
- CDC Community Health Status Indicators, www.cdc.gov/CommunityHealth
- County Health Rankings, www.countyhealthrankings.org
- Community Commons www.chna.org
- Healthy Communities Institute, www.healthycommunitiesinstitute.com
- Hospital data: Service utilization and epidemiology of common diseases
- Qualitative data: Information from individual interviews, focus groups and town hall meetings with community leaders, community members and other stakeholders

plan. A steering committee of representatives from each partner organization should create a common vision, shared language and a plan for regular communications.

Partnerships must focus on both the technical (e.g., compliance) and strategic aspects of the work. A successful partnership also requires staff with sufficient time and appropriate resources allocated to this work. Many partnerships are funded through inputs from each participating hospital and health department and should consider collaborating with the business community and area employers with an interest in health promotion.

Create better links between community health needs assessments and the allocation of community benefit resources. After the community's needs are identified, validated and prioritized, the next step is to select effective interventions. Community benefit programs have existing relationships with schools and community groups that can be leveraged and improved upon. A hospital's community benefit office can be a champion for the transition to population health management. Community benefit is one—but not the only—funding mechanism for hospitals engaged in population health work. Hospital funding is not the only financial resource for communities. For example, funding from local foundations and the local United Way can support community health improvement initiatives.

Measure the impact with a mixed-methods approach and a shared-data system. The sheer quantity of

population health data can be overwhelming; a shared set of measures is useful for hospitals to measure impact and facilitates aggregating measures to priority areas and entire communities, states, regions and even nationally. The sidebar on page 72 shows data sources and resources that can be used as part of a comprehensive community health needs assessment.

High healthcare costs and issues around health equity are plaguing communities. The community health needs assessment requirements provide an opportunity for hospital leaders to collaborate with partners in the community to coordinate assessment activity, with the aim of helping communities across the nation tackle

these pervasive problems. Although working toward improved access and clinical care is a good starting place, hospital leaders who wish to move their organizations toward the Triple Aim will need to tackle broader population health issues in collaboration with community partners. ▲



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Physician Employment Alternatives

Two lesser-known approaches can improve hospital/physician relations.

In theory, employing physicians can be a great strategy to align interests in a synergistic fashion by enhancing referral patterns and building loyalty; however, this may not always be the case. To develop a successful physician services business line, the appropriate level of resources must be dedicated to the venture that understands the physician business and creates the best opportunity for success.

Certainly, employment can be the right answer by shortening the gap between two points that initially may not have been close. Some hospital leaders are happy with employment arrangements and continue to engage in them. Others are looking at the increased level of financial exposure such relationships can occasionally create and wondering whether employment makes sense.

There are two additional approaches that, while not receiving huge amounts of attention, can be very effective in improving alignment between hospitals and physicians. And, importantly—if properly structured—neither runs afoul of the Stark law.

The first alternative can prove very powerful. Under this approach, a hospital creates a co-management arrangement with a specialty

practice group(s) to enhance a hospital service line.

Many physicians excel at providing care but do not have the time or expertise to build an effective business.

The second retains the traditional independent ownership and operating structure but helps physicians find ways to more effectively manage their practices.

Synchronized Rowing

The first approach keeps a physician group and hospital in separate ownership boats but strongly encourages them to row together. By forming a joint venture between the physician group(s) and the hospital to co-manage a hospital service line, each party gives up a certain amount of control but gains a lot of upside potential. Possible synergies include enhanced efficiencies as a result of improved staffing ratios, lower supply/implant costs, improved service quality and patient satisfaction.

To create a win-win scenario, incentive arrangements must focus on quality metrics that demonstrate improvements

in care and outcomes, such as lower nosocomial rates, improved blood conservation measures and enhanced turnover rates. Physicians in specialties such as orthopedics, cardiology, neuroscience and oncology are likely candidates for this approach as they represent high-cost areas, although other specialties also can be a good fit for this approach.

Physician preference items are one way to demonstrate how a service line joint venture can improve efficiency. These items are one of the biggest sources of supply chain costs in hospitals. Under a traditional affiliation arrangement at a hospital, orthopedic surgeons, for example, commonly use an implant brand they prefer, regardless of price. But for an orthopedist group in a joint venture, it makes financial sense to select fewer implant options, potentially maximizing the buying power of the group, ultimately reducing costs. Cardiovascular service lines have been able to decrease costs by establishing a performance measure around whether the group met appropriate use criteria for implantable cardioverter-defibrillators. These kinds of progressive strategies represent an opportunity for systems struggling to move beyond baseline efforts to impact utilization.

Decisions, of course, have to be quality and value driven. This arrangement holds the promise not only of financial reward but also improved care. When aligned physicians partner with a hospital, it becomes easier to collaboratively tackle issues like control of hospital-based infections, clinical pathways and other clinical enhancement metrics. With bundled payments and other arrangements on the horizon, it makes sense for hospitals and physicians to

work together to reduce costs, improve outcomes and financially benefit from their efforts.

As an example, a 536-bed academic medical center and a joint-venture limited liability company that represented the medical center and three orthopedic practices struck a co-management agreement. They created an orthopedic steering committee that meets on a quarterly basis and is composed of medical directors and co-management medical directors from various orthopedic sub-specialties—medical center administration, three surgeons and anesthesia physicians. The committee provides expertise in the development and implementation of critical pathways, quality metrics and materiel management standardization.

These kinds of progressive strategies represent an opportunity for systems struggling to move beyond baseline efforts to impact utilization.

From a financial perspective, the medical center reimburses the LLC for the benefits and salaries of 36 staff members' salaries and benefits. A management fee is structured in fair market value fashion for medical directors. The arrangement equates to 2.5 percent of net revenues of the overall orthopedic service line. Physicians are compensated for meeting time and other administrative duties. In addition to the base management fee, incentives are available for quality of service, operational efficiency and new program development. These are structured in measurable quality metric format. All

compensation is determined by FMV hourly and fixed at-risk compensation.

Results include a far lower incidence of minor complications in post-surgical patients managed by the orthopedics co-management teams, compared to patients managed under the standard model. In addition, 61 percent of patients in the collaborative care group left the hospital with no complications, compared to 49 percent of those treated under the standard arrangement. And the rate of minor complications was far lower—30.2 percent versus 44.3 percent—in the co-managed arrangement.

The Miracle of Good Management

Under federal law, it is illegal for a hospital to provide indirect-but-valuable benefits to a physician practice without appropriate payment. However, hospitals can suggest that physician practices partner with a practice management firm that can recommend ways to improve patient satisfaction, build revenue and reduce expense.

Many physicians excel at providing care but do not have the time or expertise to build an effective business. A referral to a practice management firm that can provide billing, management/administrative oversight, human resources management, accounting and consulting services can strengthen the quality of services the physician group provides while bolstering the physician group's relationship with the hospital providing the referral. One well-known hospital system has used this approach when acquiring hospitals, with strong success for the physician practices involved.

In one such situation, a large for-profit hospital owner/operator decided to

refer most independent physician practices to a single management services organization. This reduced the hospital's exposure and created a more satisfied physician base.

Once an alternative to the full-employment model was created, hospitals and physicians were able to enhance their overall level of trust and the environment for recruiting additional physicians improved. The hospitals also stemmed the losses on the physician front. Initially, the physicians formed an independent practice association in many of the system's markets and ultimately formed a single multispecialty group under one tax identification number, thus enabling them to share in ancillary revenues under a Stark-approved compensation model. A few of the markets actually created additional hospital-physician integration models and are now better prepared for the bundled payment program and expansion of the ACO model in the future.

Exploring a Variety of Models Is Critical

With physician alignment at the top of the priority list for many hospital executives, it makes sense to consider a variety of alternatives. Both types of arrangements represent excellent precursor-type arrangements that can lead to closer alliances between hospitals and physicians without the stress and exposure of the full-employment model. Creativity is still alive in healthcare management via collaborative synergistic models that can make sense for your hospital. ▲

Andrew D. McDonald, FACHE, is partner-in-charge for LBMC Healthcare Consulting (amcdonald@lbmc.com) in Brentwood, Tenn.

ACHE Member Update

Interim Regent Appointed



Erixon

Stephen M. Erixon, FACHE, CEO, SageWest Health Care, Lander, Wyo., has been appointed Interim Regent for Wyoming.

Keith E. Heuser, FACHE, president, CHI Mercy Health, Valley City, N.D., has been appointed Interim Regent for North Dakota.

Michael Nowicki, EdD, FACHE, professor, health administration, Texas State University, San Marcos, Texas, has been appointed Interim Regent for Texas—Central & South.

William P. Perno, FACHE, assistant vice president, Florida Hospital Healthcare System, Orlando, Fla., has been appointed Interim Regent for Florida—Eastern.

ACHE Premier Corporate Partners Gather in Chicago for Annual Forum

Several executives representing ACHE's 2015 Premier Corporate Partners convened at the annual Corporate Forum held April 29–30 in Chicago.

ACHE Chairman **Richard D. Cordova, FACHE**, president/CEO, Children's Hospital Los Angeles, welcomed the attendees, and ACHE President/CEO **Deborah J. Bowen, FACHE, CAE**, provided an overview of ACHE.

John Toussaint, MD, CEO, ThedaCare Center for Healthcare Value, Appleton, Wis., presented "Creating a Highly Reliable Healthcare Organization." Following the presentation, a reactor panel and Q&A session was held with the following panelists: **Gary Fybel, FACHE**, CEO, Scripps Memorial Hospital, La Jolla, Calif.; **Colleen Kannaday, FACHE**, president, Advocate BroMenn Medical

Center, Normal, Ill.; and **Jayne Pope, FACHE**, CEO, Hill Country Memorial Hospital, Fredericksburg, Texas. **Susan E. Lawler, PhD**, vice president, Division of Professional Development, ACHE, moderated the session.

A CEO panel and Q&A featured **Gyasi Chisley, FACHE**, CEO, Methodist Healthcare North, Memphis, Tenn.; **Zeff Ross, FACHE**, senior vice president/CEO, Memorial Regional Hospital, Hollywood, Fla.; and **Mary Starmann-Harrison, FACHE**, president/CEO, Hospital Sisters Health System, Springfield, Ill.

ACHE 2015 Premier Corporate Partners participating in the forum included Aramark, athenahealth, Cardinal Health, CareFusion (now a BD Company), Cerner, Conifer Health Solutions, Philips Healthcare, The Risk Authority—Stanford and Trane Healthcare.

People

Member-Led Organizations Honored for Improving Community Health

Six ACHE member-led organizations have been awarded the 2015 American Hospital Association NOVA Award, which recognizes hospital-led collaborative efforts that improve community health.

- PIH Health, Whittier, Calif., led by president/CEO **James R. West**, for Activate Whittier, a community-wide program to combat obesity.

- Florida Hospital, Orlando, Fla., led by president/CEO **Lars D. Houmann, FACHE**, for Bithlo Transformation Effort, a project to transform the city of Bithlo, Fla., due to its lack of clean water, safe housing and adequate public transportation, and unemployment, illiteracy and homelessness.

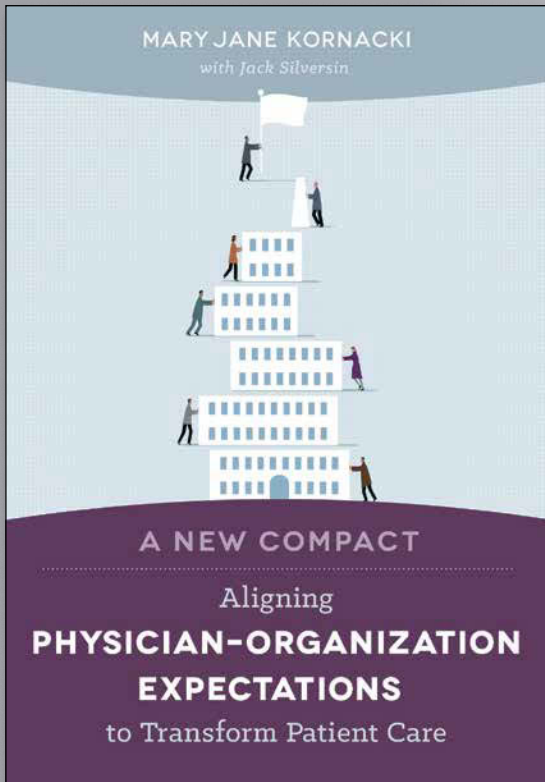
Baton Rouge (La.) General Medical Center, led by president/CEO **Mark F. Slyter, FACHE**; Ochsner Medical

Center, Baton Rouge, La., led by CEO **Eric McMillen, FACHE**; Our Lady of the Lake Regional Medical Center, Baton Rouge, La., led by president/CEO **K. Scott Wester, FACHE**; and Woman's Hospital, Baton Rouge, La., led by president/

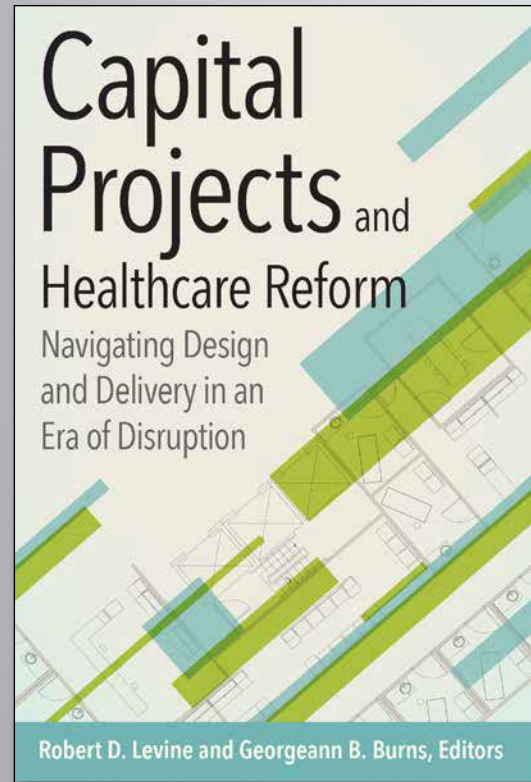
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CEO **Teri G. Fontenot, FACHE**, for the Mayor's Healthy City Initiative,

which identifies and creates efforts dedicated to healthier eating and

more active lifestyles across the City-Parish.

Leaders in Action

To promote the many benefits of ACHE membership, the following ACHE leaders have recently spoken at local, state/provincial, regional, national and international meetings:

Christine M. Candio, RN, FACHE, Immediate Past Chairman
Utah Hospital Association Annual

Meeting/Utah Health Executive Meeting
St. George, Utah

Richard D. Cordova, FACHE
Chairman
ACHE Corporate Forum
Chicago

AHA Annual Membership Meeting
Washington, D.C.

Michael A. King
Governor, FACHE
Virginia Hospital & Healthcare Association Annual Meeting
Williamsburg, Va.

ACHE Staff Update

ACHE Announces Staff Hires, Promotions

Following are new ACHE staff members and current employees who have recently moved into new positions at ACHE:

Tammy G. Dillard-Steels, CAE, to regional director, Division of Regional Services

Sonia S. Hernandez to senior secretary, Executive Office, from secretary

Kaitlin McKinney to marketing specialist, Health Administration Press

Carla M. Nessa to senior graphic designer, Division of Communications and Marketing, from graphic design specialist

Theresa L. Rothschild to editor, Health Administration Press

Craig C. Thompson to performance excellence director, Executive Office, from performance excellence manager

Christian M. Volpe to marketing specialist, Division of Member Services, from marketing coordinator



In Memoriam

ACHE regretfully reports the following deaths of ACHE members as reported by the Division of Member Services:

Cristine S. Brown
Grand Prairie, Texas

Lourdes D. Carvalho, MD, FACHE
Sao Paulo, Brazil

Kenneth H. Cohn, MD
Amesbury, Mass.

Katherine J. Corrigan, FACHE
Scottsdale, Ariz.

Onax F. Garcia
Palm Bay, Fla.

Robert F. Haas, FACHE
Jacksonville, Fla.

Dennis E. Miller, FACHE
Franklin, Tenn.

Bonnie L. Peterson
Lawrence, Kan.

Louis A. Rabb, FACHE
Tuskegee Institute, Ala.

James E. Robertson Jr., FACHE
Trinidad, Colo.

Robert M. Schnitzer, FACHE
Bradenton, Fla.

George R. Strohl Jr., FACHE
East Waterford, Pa.

Ronald H. Wallace, FACHE
Augusta, Maine

Why do CEOs like you work so hard?
Because you care that much.



Share your passion
Encourage your management
team to join ACHE.

Together, we can foster a culture of healthcare leaders who care as much as you do. We have the resources to help your team excel in healthcare management. Recommend that they become a part of ACHE.



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You may also contact us at (312) 424-9400 or contact@ache.org for membership information.



Dewerff



Foulkes



Hernandez



Ransom



Spong



Trenchel

Stuart B. Almer, FACHE, to administrator/COO, Gurwin Jewish Nursing & Rehabilitation Center, Commack, N.Y., from administrator/COO, Parker Jewish Institute for Health Care and Rehabilitation, New Hyde Park, N.Y.

John G. Anderson, FACHE, to president/CEO, Anderson Regional Medical Center, Meridian, Miss., from interim CEO.

Byron G. Atkinson to vice president/leadership advisor, interim leadership and advisory services, B.E. Smith, Lenexa, Kan., from CEO, IBR Healthcare Consulting, Vernon Hills, Ill.

Kendra A. Aucker to president/CEO, Evangelical Community Hospital, Lewisburg, Pa., from vice president/COO, Evangelical Medical Services Foundation, Lewisburg, Pa.

Patrick A. Auman, PhD, to interim CEO, Susan B. Allen Memorial Hospital, El Dorado, Kan., while maintaining his role as president/CEO, The Network Job List Companies, Houston.

Kurt Banas, FACHE, to senior manager, Deloitte Consulting, McLean, Va., from senior director, value analysis and strategic sourcing, Inova Health System, Falls Church, Va.

Cynthia C. Barginere, RN, FACHE, to senior vice president/COO, Rush University Medical Center, Chicago, from vice president clinical nursing/CNO.

Kim Barnas to president, ThedaCare Center for Healthcare Value, Appleton, Wisc., from senior vice president.

Jahansha Behzad, FACHE, to CEO, Rehabilitation Institute of Southern California, Orange from administrator, physical medicine and rehabilitation, Johns Hopkins Medicine, Baltimore.

James A. Berg, FACHE, to president, Texas Health Presbyterian Hospital Dallas from senior vice president/COO.

Jeffrey W. Bloemker to CEO, I-70 Community Hospital, Sweet Springs, Mo., from vice president, Mosaic Life Care, St. Joseph, Mo.

Thomas F. Boggs, CPA, to CEO, Healthcare Solutions Network, Cincinnati, from COO, Aultman Health Foundation, Canton, Ohio.

Timothy Brady, PhD, FACHE, to retirement from regional inspector general, HHS OIG, San Francisco. We would like to thank Timothy for his many years of service to the healthcare field.

David T. Brooks, FACHE, to president, St. Joseph Mercy Ann Arbor (Mich.) and St. Joseph Mercy Livingston (Mich.) from president, St. John Hospital & Medical Center, Detroit.

James T. Callaghan III, MD, FACHE, to CEO, Franciscan St. Francis Health, Carmel, Ind., Indianapolis and Mooresville, Ind., from president, Franciscan St. Anthony Health, Michigan City, Ind.

Jennie H. Chahanovich, FACHE, to president/CEO, Wilcox Memorial Hospital and Kauai Medical Clinic, Lihue, Hawaii, from CEO, Hawaii Pacific Health-Pali Momi Medical Center, Aiea, Hawaii.

Richard C. Cleland, FACHE, to CEO, Erie County Medical Center Corporation, Buffalo, N.Y., from president/COO and interim CEO.

Kenneth J. Cochran, FACHE, to president/CEO, Opelousas (La.) General Health System from president/CEO, River Valley Health Partners, East Liverpool, Ohio.

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This column is made possible in part by The Risk Authority.



THE RISK AUTHORITY
STANFORD

Melissa Cole, FACHE, to director, ophthalmology clinics, UNM Hospitals, Albuquerque, N.M., from quality consultant, UNM Hospitals.

Thomas A. DeBord, FACHE, to COO, Overlake Medical Center, Bellevue, Wash., from president, Summa Barberton & Wadsworth-Rittman Hospital, Akron, Ohio.

Michael Dewerff to president/CEO, UnityPoint Health—Fort Dodge from CFO.

Steve E. Dobbs, FACHE, to CEO, Merit Health, Jackson, Miss., from CEO, Urologic Specialists of Oklahoma, Tulsa.

Elizabeth A. Durrence, FACHE, to COO, Brandon (Fla.) Regional Hospital from COO, Kendall Regional Medical Center, Miami.

William G. Englert to CEO, Allegheny Valley Hospital, Natrona Heights, Pa., from vice president, operations and business development.

J. Eric Evans, FACHE, to CEO, Tenet Texas Region, Dallas, from market CEO, Providence Memorial Hospital and Sierra Medical Center, El Paso, Texas.

Delvecchio S. Finley, FACHE, to CEO, Alameda Health System, Oakland, Calif., from CEO, Harbor-UCLA Medical Center, Torrance, Calif.

Joshua A. Floren, FACHE, to president, Texas Health Presbyterian Hospital Plano, from interim president.

Terry J. Fontenot, FACHE, to CEO, Nix Health, San Antonio, from president, Executive Healthcare Management and Consulting Services, Sachse, Texas.

Bill Foulkes II to national vice president, healthcare project management, Cumming, Aliso Viejo, Calif., from vice president, Hammes Company, Irvine, Calif.

Susan Fox to president/CEO, White Plains (N.Y.) Hospital from president.

John A. Gennaro, FACHE, to director, Cincinnati VA Medical Center from director, VA Butler (Pa.) Healthcare.

Greg D. Gerard to vice president, ambulatory services, Baptist Health Richmond (Ky.) from president, Saint Joseph London (Ky.).

Karen T. Harris, RN, to chief nursing and operations executive, Henry Ford West Bloomfield (Mich.) Hospital from vice president, patient care services and CNO.

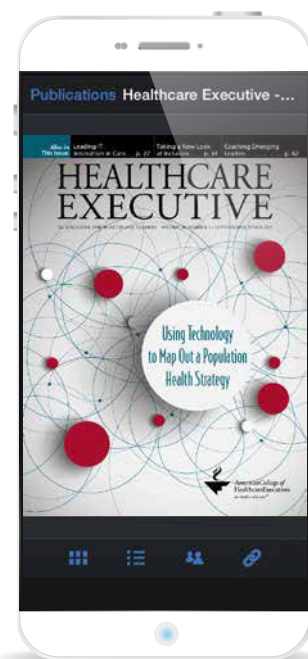
Sandy S. Haryasz, FACHE, to retirement from CEO, Page (Ariz.) Hospital. We would like to thank Sandy for her many years of service to the healthcare field.

Beth E. Hawley, FACHE, to senior vice president, strategic initiatives, IPC Healthcare Inc., North Hollywood, Calif., from chief customer experience officer, Cogent HMG, Radnor, Pa.

Henry “Hank” Hernandez to CEO, Sierra Providence Transmountain Campus, Sierra

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Providence Health Network, El Paso, Texas, and COO, Sierra Providence Health Network from CEO, Las Palmas Medical Center, El Paso, Texas.

Mary Anne Healy-Rodriguez, PhD, RN, to senior vice president and chief nursing executive, The Brooklyn (N.Y.) Hospital Center from vice president, nursing operations.

J. Michael Horsley, FACHE, to retirement from president/CEO, Alabama Hospital Association, Montgomery. We would like to thank J. Michael for his many years of service to the healthcare field.

Sally A. Hurt-Deitch, FACHE, to market president/CEO, Sierra Providence Health Network, El Paso, Texas, from president/CEO, Sierra Providence Eastside Hospital, El Paso, Texas.

Edward Jimenez to CEO, University of Florida Health, Gainesville, from interim CEO.

Fran Laukaitis, RN, FACHE, to president, Methodist Charlton Medical Center, Dallas, from CNO.

Karen A. Lautermilch to CEO, Coquille (Ore.) Valley Hospital from CEO, Rehoboth McKinley Christian Health Care Services, Gallup, N.M.

Bruce Lederman to COO, Charles E. Smith Life Communities, Rockville, Md., from chief strategy officer, Midwest Administrative Services Inc., Chicago.

Theodore M. Lewis to CEO/administrator, Guam Memorial Hospital, Tamuning, from president/CEO, Guam Seventh-Day Adventist Clinic, Tamuning.

Chris Locke to CEO, Saint Francis Hospital-Bartlett (Tenn.), from COO, Atlanta Medical Center.

Stephen A. Martin Jr., PhD, to CEO, Accreditation Association for Ambulatory Health Care, Skokie, Ill., from executive director, Association for Community Health Improvement at the American Hospital Association, Chicago.

Federico Martinez Jr. to retirement from CEO, St. Charles Parish Hospital, Luling, La. We would like to thank Federico for his many years of service to the healthcare field.

R. Craig McCoy to CEO, Bon Secours Saint Francis Health System, Greenville, S.C., from CEO, Emory Saint Joseph's Hospital, Atlanta.

Cameron M. McGregor, RN, FACHE, to vice president, neuroscience and Oncology Institutes, Premier Health, Dayton, Ohio, from director, operational innovation, Premier Health.

Rachael L. McKinney, FACHE, to COO, VEP Healthcare, Inc., Walnut Creek, Calif., from regional neuroscience executive, Sutter Health Sacramento Sierra Region (Calif.)

Bradley D. Pfeifer, FACHE, to CEO, West Holt Medical Services, Atkinson,

Neb., from manager, marketing and business development, Nebraska Orthopaedic Hospital, Omaha.

Richard J. Pollack to president/CEO, American Hospital Association, Chicago, from executive vice president, advocacy and public policy.

London A. Quicci to COO, DMC Sinai-Grace Hospital, Detroit, from administrator, DMC Surgery Hospital, Madison Heights, Mich.

Natalie Ransom to CNO, North Florida Regional Medical Center, Gainesville, Fla., from CNO, Mountainview Hospital, Las Vegas.

Virginia Razo, PharmD, DsC, to interim CEO, Curry Health Network, Gold Beach, Ore., from COO, Tahoe Forest Hospital, Truckee, Calif.

Norman G. Roth, FACHE, to president, Greenwich (Conn.) Hospital and executive vice president and COO, Bridgeport Hospital, Yale New Haven (Conn.) Health System from interim president.

Nikki K. Roux, FACHE, to vice president/CNO, Memorial Hermann Northeast Hospital, Humble, Texas, from administrative director, general medicine, services, Memorial Hermann-Texas Medical Center, Houston.

Candice L. Saunders, FACHE, to president/CEO, WellStar Health System, Marietta, Ga., from president/COO.

Brian W. Schroeder, JD, MPH, CMPE, to executive director,

operations, Vanguard Medical Group, Cranford, NJ., from regional director, physician practices, Barnabas Health Medical Group, Newark, N.J.

Kevin Scoggin to COO, Summerville (S.C.) Medical Center from associate COO, Kingwood (Texas) Medical Center.

Susan C. Shugart, FACHE, to COO, Carolina Pines Regional Medical Center, Hartsville, S.C., from chief administrative officer, Baptist Easley (S.C.) Hospital.

Mark D. Sparta, FACHE, to executive president and chief population health officer, Hackensack (N.J.) University Health Network from vice president, senior operations officer, Hackensack (N.J.) University Medical Center.

Bernadette Spong, CPA, to CFO, Orlando (Fla.) Health from CFO, Rex Healthcare, Raleigh, N.C., and senior vice president, finance, University of North Carolina Health Care System, Raleigh, N.C.

Michael J. Swartz, FACHE, to interim director, Canadagua (N.Y.) VA Medical Center while continuing as medical center director, Bath (N.Y.) VA Medical Center.

Suanne L. Thurman-Gersdorf, FACHE, to CEO, Tulsa (Okla.) Cancer Institute from vice president, corporate service lines, Valley Health Services, Winchester, Va.

Robert J. Trenchel, DO, FACHE, to president/CEO, Yuma (Ariz.)

Regional Medical Center from administrator/CEO, Ben Taub Hospital/Quentin Mease Hospital, Harris Health System, Houston.

Gary C. Tucker, FACHE, to president/CEO, Mt. St. Mary's Hospital and Health Center, Lewiston, N.Y., from senior vice president/COO.

William Voloch to president/CEO, Wesley Medical Center, Wichita, Kan., from interim CEO.

Tiffany Weber to CFO, Sterling (Colo.) Regional MedCenter from CFO, Perkins County Health Services, Grant, Neb.

Michael S. Wiggins, FACHE, to senior vice president, administrator, Children's Medical Center Plano, Texas, from vice president, operations, Children's of (Birmingham) Alabama.

Lynn R. Wold to president/CEO, UnityPoint Health-St. Luke's, Sioux City, Iowa, from interim president.

Editor's note: Submissions to *On the Move* must be submitted by Aug. 1 to be considered for the November/December issue due to production lead times. See page 4 for additional submission information.

Are you interested in an **ACHE** Fellowship or Internship?

Stuart A. Wesbury Jr. Postgraduate Fellowship

This one-year fellowship program furthers postgraduate education in healthcare and professional society management. Beginning in May or June, the program allows the Fellow to work in all major ACHE divisions.

You are eligible to apply if:

You have earned a graduate degree in healthcare or association management from a college or university that is accredited by the regional accrediting association in the United States approved by the U.S. Department of Education or that holds membership in the Association of Universities and Colleges of Canada. The degree must have been granted no earlier than July 2015. You are authorized to work for any employer in the United States. ACHE does not sponsor visas.

Diversity Internship

This three-month internship program furthers the education of diverse students in the fields of healthcare and professional society management. Beginning in May or June, the program allows the Intern to rotate through all major ACHE divisions.

You are eligible to apply if:

You have successfully completed one year of graduate studies in a healthcare or association management program at a college or university that is accredited by the regional accrediting association in the United States approved by the U.S. Department of Education or that holds membership in the Association of Universities and Colleges of Canada. You are a minority as classified by EEOC.

For application information, visit ache.org/CareersResources, or contact ACHE's Human Resources at (312) 424-9341 or hr-intern-fellow@ache.org. Applications must be postmarked no later than December 1, 2015.



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

Nicholas Bilas, division administrator, Columbia University Medical Center, New York, received the Early Career Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Karen C. Brown, FACHE, vice president/COO, OSF Saint Anthony Medical Center, Rockford, Ill., received the Senior-Level Healthcare Executive Award from the Regent for Illinois—Central and Southern.

William A. Burmeister, FACHE, director, physician practice relations, Middlesex Hospital, Middletown, Conn., received the Early Career Healthcare Executive Award from the Regent for Connecticut.

Dee Dee Chen, FACHE, professional staff benefits manager, Massachusetts General Hospital, Boston, received the Early Career Healthcare Executive Award from the Regent for Massachusetts.

John A. Christoforo, FACHE, president/CEO Beth Israel Deaconess Healthcare, Needham, Mass., received the Senior-Level Healthcare Executive Award from the Regent for Massachusetts.

Heather DeCoster, administrative fellow, Spectrum Health System, Grand Rapids, Mich., received the Student Award from the Regent for Michigan & Northwest Ohio.

David J. DeSimone, FACHE, director, planning and business development, McLaren Flint (Mich.), received the Faculty Award from the Regent for Michigan & Northwest Ohio.

John C. Federspiel, president, Hudson Valley Hospital Center, Cortlandt Manor, N.Y., received the Senior-Level Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Amanda A. Henson, FACHE, vice president, oncology, Baptist Health Lexington (Ky.), received the Early Career Healthcare Executive Award from the Regent for Kentucky.

James H. Jackson Jr., executive director, Greenwood (Miss.) Leflore Hospital, received the Senior-Level Healthcare Executive Award from the Regent for Mississippi.

Leslie R. Johnson, senior process improvement engineer, Silver Cross Hospital, New Lenox, Ill., received the Early Career Healthcare Executive Award for Illinois—Central and Southern.

Jay A. Kossman, senior director, JLL, Norfolk, Va., received the Senior-Level Healthcare Executive Award from the Regent for Connecticut.

Charles D. Lovell Jr., FACHE, CEO, Caldwell Medical Center, Princeton, Ky., received the Senior-Level Healthcare Executive Award from the Regent for Kentucky.

Karen S. Lower, RN, director, oncology services, Champlain Valley Physicians Hospital, Plattsburgh, N.Y., received the Senior-Level Healthcare Executive Award from the Regent for New York—Northern and Western.

Stanley E. McBride, FACHE, Cincinnati, received the Leadership Award from the Regent for Ohio.

Christine D. Soufastai, project manager, New York Presbyterian Hospital, received the Early Career Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Henry A. Veenstra, FACHE, president, Spectrum Health Zeeland (Mich.) Community Hospital, received the Senior-Level Healthcare Executive Award from the Regent for Michigan & Northwest Ohio.

Elissa M. Waliszewski, FACHE, director, performance management, Westchester Medical Center, Valhalla, N.Y., received the Early Career Healthcare Executive Award from the Regent for New York—Metropolitan New York.

Editor's note: Submissions to Member Accolades must be submitted by Aug. 1 to be considered for the November/December issue due to production lead times. See page 4 for additional submission information.

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The American College of Healthcare Executives Board of Governors met June 28–30 in San Diego. Following are highlights of that meeting.

Financials Approved

The Board received financial statements for the current period and accepted ACHE's 2014 financial audit, prepared by McGladrey LLP. The auditors issued an unmodified opinion regarding the audit.

Governance Review Task Force Report

The Board received and reviewed the preliminary report and recommendations of the Governance Review Task Force. The task force, comprising ACHE leaders who have

served on the Board of Governors and/or the nominating committee, was charged with conducting a review of ACHE's board-level structures and processes and recommending changes that would better align these with ACHE's strategic direction and increase ACHE's ability to respond proactively and rapidly to changes in the environment.

The task force identified and proposed recommendations related to four key issues:

- Board competencies and composition
- Board nomination and selection process
- How to effectively ensure input from stakeholders
- Use of Board meeting time

Following discussion of the recommendations, the Board approved the report for field review by ACHE past Chairmen, Regents and chapter presidents. This review began in late July.

Staff Reports and Updates

The Board also heard reports from staff regarding corporate and divisional performance objectives, member attrition trends, ACHE's performance excellence journey, progress toward implementation of ACHE's 2015–2017 Strategic Plan and the initiative to replace ACHE's current association management system.

Strategic Planning Session

The ACHE 2015–2017 Strategic Plan and the March 31, 2015, progress report are available on ache.org.

The Board participated in a half-day strategic planning retreat to consider opportunities to enhance ACHE's current strategic plan and the initiatives that have arisen since development of the plan in November 2014. The Board received both quantitative and qualitative information related to each opportunity. After careful consideration, the Board made a few modifications to the plan for 2016–2018, including a change designed to more effectively communicate key components of the plan with members. The Board expressed its enthusiasm about ACHE's strategy and its confidence that the 2016–2018 plan will build on the current direction. The Board also approved additional resources and funding for 2015 to ensure continuity and continued progress toward the plan's implementation.

Board Self-Assessment Reported

ACHE uses a board self-assessment process developed by Board Source and the American Society of Association Executives. The Board reviewed the results of the evaluation.

Next Meeting Planned

The ACHE Board of Governors is scheduled to meet Nov. 9–10, 2015, in Chicago. Highlights of that meeting will be published in a future issue of *Healthcare Executive*.

LEADERSHIP
DEVELOPMENT
PROGRAM



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and CONFIDENCE

NOV. 2–4, 2015
CHICAGO MARRIOTT O'HARE
ACHE.ORG/LDP

Thank You

To our members and customers from the American College of Healthcare Executives Board of Governors, Council of Regents and staff for your support and contributions during the past year. We also extend our gratitude to our committee members and nearly 1,500 leaders and volunteers of our partners—the 80 independent chapters of ACHE—for your contributions. See what we have achieved together:

Reached the largest **MEMBERSHIP** in our history with more than 45,000 members

- Chapters provided more than 1,000 events for more than 67,000 attendees
- Nearly 600 new Fellows recognized the value of the FACHE® credential
- Nearly 2,400 members served as sponsors through the Leader-to-Leader Program, resulting in the recruitment and advancement of more than 2,500 members
- Our Physician Executives Forum and Healthcare Consultants Forum continued to grow and expand offerings to these executive segments

Advanced **KNOWLEDGE** in the field through educational programs and publications

- The 2015 Congress on Healthcare Leadership was attended by more than 4,000 healthcare executives from more than 30 countries
- *Healthcare Executive* magazine continues to be one of the most widely read publications in the field
- Health Administration Press published 14 new books and 10 journal issues and sold about 55,000 publications

Provided **CAREER ADVANCEMENT** resources for all members

- The online Job Center housed on average 2,500 jobs and 3,000 searchable resumes
- The Career Resource Center responded to more than 2,100 member requests for service
- The American College of Healthcare Executives Official Group on LinkedIn provided social networking opportunities for nearly 14,000 members

Demonstrated a commitment to **LEADERSHIP**

- ACHE's *Code of Ethics*, online ethics toolkit and regular ethics columns in *Healthcare Executive* promote a commitment to ethics in the field
- The Thomas C. Dolan Executive Diversity Program achieves greater diversity among senior healthcare leaders; six scholars were selected for the 2015 program
- ACHE continued its support of the Equity of Care initiative to help eliminate disparities in care

Set a high standard of **SERVICE EXCELLENCE**

- Nine Premier Corporate Partners have committed their support, making additional programs and services available
- More than 1,900 donors to the Fund for Innovation in Healthcare Leadership contributed more than \$2.9 million since its inception

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Engaging Early Careerists

Chapters have a number of resources to support early careerist development.

ACHE chapters can seek out creative ways to help early careerists become involved with their chapter. They can provide career services, such as mentoring and resume review, and they may appoint an early careerist on the chapter board to provide a fresh perspective. One chapter—Healthcare Executive Forum, Inc., which covers a large geographic area in western New York—developed programs to engage and foster connections with early careerists.

HEF has 140 members, but before 2013 the chapter did not have many programs that targeted early careerists. They also lacked funds to implement its ideas for recruiting up-and-coming leaders, so in 2013 it applied for and received the 2013 Grant for Chapter Innovation for its Early Careerist Development Initiative.

HEF President Vi-Anne Antrum, RN, FACHE, lead CNO, for Kaleida Health, Buffalo (N.Y.) General Medical Center, who was the chapter's program committee chair at the time, led the initiative's implementation. The objectives were to offer more ACHE Qualified Education credit programs that would attract a diverse group of executives to serve as presenters; provide a Board of Governors Exam study group to encourage advancement; lead an effort to appoint early careerists to the chapter board; and increase the number of programs offered in less populated areas of the chapter's region.

"This was a good way to get senior executives engaged, and early careerists were eager to have a dialogue with them," Antrum says. "Plus, having a diverse board would help with career progression."

Building upon 2013's efforts, HEF established three sustainable career assistance services for early and mid-careerists. The first was the "Conversations with an Executive" series, which featured local senior executives who shared their professional journeys and offered career advice. Next was the resume review workshop, where local healthcare executives and healthcare system recruiters offered guidance to early careerists through a panel discussion on resumes and met with them one-on-one to review and critique. The third was a speed networking event that included three 20-minute sessions of roundtable discussions, which allowed early careerists to network and receive advice.

"Chapters can help early careerists develop in their career," Antrum says. "It is invigorating to have that high level of excitement and energy."

HEF has reaped enormous benefits from these initiatives. In 2014, the chapter received the Board of Governors Award for exceeding all four goals outlined in the Chapter Management and Awards Program, including an increase in member

satisfaction. In 2012, there were no early careerists on the chapter board; by 2013, two early careerist members were represented on the board; and in 2014, four early careerists were appointed. Overall attendance at chapter programs has grown from an average of 20 attendees to 40. The number of Fellows in the chapter increased, and many of the senior-level executives who led early careerist programs offered to be mentors to these young healthcare professionals.

"Early careerists bring enthusiasm and time to dedicate to chapter activities," Antrum says. "They have the opportunity to develop different skill sets, bring fresh ideas and offer new ways of doing things."

ACHE's Early Careerist Network

If you are a member of ACHE and are under the age of 40, you automatically belong to the Early Careerist Network. The ECN's resources, many of which are available online, are designed to help you navigate the increasingly complex professional challenges facing early careerists in healthcare. Benefits include the Early Careerist Newsletter, ACHE discounts, educational programs, and networking and mentoring opportunities. For more information, go to ache.org/ECN. ▲

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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Opportunities await at your local ACHE chapter.

ache.org/Chapters



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ACHE Chapters

LEADERSHIP

EDUCATION

ADVANCEMENT

NETWORKING

GET IT
AND
COME

January 2016

18–21



St. Petersburg, Fla., Cluster

- 18–19 The Courage to Lead: Critical Skills for Healthcare Leaders
 - Journey to Excellence: How High-Performing Healthcare Leaders Achieve Organizational Success
 - Strategic Planning: From Formulation to Action
- 20–21 Developing and Deploying a Hospital Business Intelligence Strategy That Works
 - Effective Leadership for High-Reliability Healthcare
 - Redesign and Operationalize Your Medical Staff for Health Reform

25–28



Beaver Creek, Colo., Cluster

- 25–26 Behavior Smarts: Increasing Healthcare Leadership Performance
 - Coach, Challenge, Lead: Developing an Indispensable Management Team
 - Possibilities, Probabilities and Creative Solutions: Breakthrough Thinking for Complex Environments
- 27–28 Leading for Success: Creating a Committed Workforce
 - Managing Conflict, Accountability Conversations and Disputes

February 2016

15–18



Scottsdale, Ariz., Cluster

- 15–16 Critical Financial Skills for Hospital Success
 - Reducing the Financial Impact of Hospital Readmissions and Medical Mistakes
 - Secrets of Great Healthcare Organizations in Leading Change
- 17–18 Achieving a Strategic Partnership With Your Board: Thrive in the Midst of Accountability
 - Aggressively Improve Cost, Quality and Throughput Using Lean Six Sigma
 - Are Medical Groups in Your Portfolio? Critical Factors to Manager Your Investment
 - Hospitals and Integrated Networks of the Future

Tuition Waiver Assistance

The American College of Healthcare Executives makes a limited number of education tuition waivers available to ACHE Members and Fellows. Tuition waivers are awarded on the basis of financial need. Applications must be submitted at least eight weeks prior to the program date. For more information on the ACHE Tuition Waiver Assistance Program, visit ache.org/TuitionWaiver or contact ACHE's Customer Service Center at (312) 424-9400.

Completion of these course(s) earns ACHE Face-to-Face Education credit, which counts toward Fellow advancement and recertification. Visit the Credentialing area of ache.org for more information on advancement and recertification requirements.

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 This column is made possible in part by Cerner.





ACHE Recognition Program SHOW YOUR STARS

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

Award levels:

- ★★★ Exemplary Service Award = 125 points
- ★★ Distinguished Service Award = 75 points
- ★ Service Award = 30 points

You will be recognized by your chapter with a prestigious service award and pin when you reach each level.

Report and track your volunteer service on My ACHE today!

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May 1992
May 1995 (revised)
December 1998 (revised)
March 2002 (revised)
November 2006 (revised)
November 2009 (revised)

Statement of the Issue

Despite the passage of the Americans with Disabilities Act in 1990, disability, whether actual or perceived, presents an ongoing employment challenge in our society. Even in the case of healthcare organizations, which face periodic personnel shortages in administrative, clinical and support functions, persons with disabilities may not be sought after as willing, productive resources for employment.

Obstacles to including the disabled in the pool of potential employees may be related to misperceptions about accommodation and healthcare costs, productivity losses, reliability of workers, how to access potential candidates and, in many communities, the lack of reliable transportation. While significant infrastructure investments and systematic process modifications may be needed to achieve organizational compliance with regulations such as those included in the Americans with Disabilities Act, research suggests that the additional costs to accommodate employees with a disability may be minimal or non-existent and that people with disabilities have lower rates of turnover and absenteeism (Job Accommodation Network, 2009).

However, there is evidence that healthcare organizations may already be more likely to employ those with disabilities than organizations in other sectors. While in 2009 4 percent of all civilian workers were disabled, a 2005 survey of members of the American College of Healthcare Executives (ACHE) showed a somewhat higher rate, with an estimated 7.6 percent of respondents being disabled, defined as having a condition that limits full participation in work and/or having specific conditions such as

learning, emotional or mental disability or disease; a sensory impairment; physical handicap; pain; or chronic fatigue syndrome.

The prevalence of disability among healthcare workers creates a particular responsibility for healthcare executives to be vigilant in ensuring ongoing opportunities for persons with disabilities while fostering an inclusive environment with equitable workplace treatment for all.

Policy Position

ACHE believes healthcare executives should take the lead in their organizations to increase employment, advancement and leadership opportunities for persons with disabilities. Additionally, healthcare executives should advocate on behalf of the employment of persons with disabilities in other organizations in their communities.

ACHE encourages all healthcare executives to pursue the following actions:

- Develop an organizational culture that encourages persons with disabilities to utilize their potential to contribute rather than discounting them on the basis of stereotypes or generalizations about their “limitations.”
- Create ongoing programs on disability awareness to educate those within human resources departments/divisions, supervisors and co-workers.
- Affirm equal access to employment for persons with disabilities exists by recruiting governance leaders, executives, clinicians and support staff with auxiliary aids and services (such as Braille or large-print materials, telecommunication devices for deaf persons and

Strengthening Healthcare Employment Opportunities for Persons With Disabilities (cont.)

videotext displays); through using networks and recruiting firms committed to accommodating persons with disabilities; and by making auxiliary assistance available throughout the interview process.

- Reallocate or redistribute job responsibilities to accommodate individuals with disabilities and consider reallocating responsibilities to accommodate and retain individuals already on staff who acquire a disability.
- Determine appropriate accommodations using an informal, interactive problem-solving process involving the employer and the individual with a disability. The employer may wish to seek the assistance of a third party who is knowledgeable in disability matters, such as a vocational rehabilitation counselor.

The American College of Healthcare Executives encourages its members to take the lead in their organization and their community in creating working environments that enhance the opportunities of persons with disabilities to gain and maintain employment.

Approved by the Board of Governors of the American College of Healthcare Executives on November 16, 2009.

References

Research cited can be found at: Job Accommodation Network (original 2005, updated 2007, updated 2009). "Workplace Accommodations: Low Cost, High Impact." Retrieved September 23, 2009, from <http://www.jan.wvu.edu/media/LowCostHighImpact.doc>



Organ/Tissue/Blood/Blood Stem Cells Donation Process

November 1986
March 1993 (reaffirmed)
February 1997 (revised)
November 2000 (revised)
November 2003 (revised)
November 2006 (revised)
November 2009 (revised)
November 2014 (revised)

Statement of the Issue

Medical advances have provided a tremendous opportunity to save and heal lives through organ, tissue, blood and blood stem cells (marrow, peripheral blood and umbilical cord blood) transplantation. More than 20,000 lives are saved or healed each year through transplantation but, tragically, thousands more die while waiting for a lifesaving organ. This is because not enough organs are available for the increasing number of people added to the transplant waiting list each year. At any given time, more than 100,000 people in the United States are waiting for a lifesaving or life-changing organ. Despite significant improvements in the donation process in hospitals across the country, the transplant waiting list continues to outpace the number of donors available.

Significant opportunities exist to increase both the proportion of eligible donors who become donors and the number of organs and tissues transplanted per donor. To increase donation and transplantation:

- Ensure specific hospital procedures are developed in collaboration with affiliated organ and tissue procurement organizations to work with patients and families in honoring patient wishes to become a donor. Successful recovery of organs requires a coordinated approach to discuss donation with family members and significant others, recognizing that in some cases the broader definition of family can include significant others.

- Provide information to enable the organ procurement organization or referral center to access donor registries and support patient authorization for donation as documented in the registries.
- Adopt best practices for achieving donation goals designated by the U.S. Department of Health and Human Services Health Resources and Services Administration and championed by the Donation and Transplantation Community of Practice.
- Heighten public and professional awareness of the problem and distribute information related to potential solutions.

Though governments, medical professionals, hospitals, organ procurement organizations and insurance companies can provide resources that support donation, only individuals and their families have the ultimate power to offer the gift of life.

Policy Position

The American College of Healthcare Executives believes all healthcare executives should work to increase the supply of available organs, tissues, blood and blood stem cells (marrow, peripheral blood and umbilical cord blood) for transplantation. ACHE recognizes donation as a critical component of lifesaving technology and end-of-life decision making and supports voluntary efforts to increase organ, tissue, blood and blood stem cells availability (see related Ethical Policy Statement: “Decisions Near the End of Life”).

Organ/Tissue/Blood/Blood Stem Cells Donation Process (cont.)

As business and community leaders, healthcare executives have the influence and credibility to motivate individuals and families to consider the donation of organs, tissues, blood and blood stem cells. As healthcare professionals, it is part of their responsibility to do everything possible to honor someone's wishes to be a donor. ACHE encourages its members to actively pursue the following:

Establish Protocols and Information Programs

- Together with their affiliated organ and tissue procurement organization, establish effective and compassionate protocols for working with patients and their families. Families of dying patients who have not registered as donors should be provided with the information and option to donate. Families of designated donors should be provided with information and support. Many appreciate the opportunity to ease their personal loss with a selfless, giving act and to help their loved ones carry out a lifesaving gift.
- Develop strong, ongoing public information and education programs that help people understand the process of organ and tissue donation, the advantages of registering with their state donor registry and the importance of sharing with their families the decision they have reached.
- Develop strong, ongoing public information and education programs that help people understand the process of blood donation and how to become a potential marrow, peripheral blood stem cells or umbilical cord blood donor.
- Support efforts to provide access to state donor registries by people in the hospital community.

Encourage Donation

- Encourage members of the medical community, particularly physicians in the critical care setting, to develop protocols reflecting the best practices in the field to maximize organ, tissue, blood and blood stem cells donation, availability and transplantation.

- Consider serving as a role model by publicizing their own personal decision to register as an organ and tissue donor, participate in blood drives or join the marrow registry. Healthcare executives can provide leadership in the resolution of this important social problem by encouraging their staff to follow their lead and in coordinating community efforts.
- Participate in national, state and local government and private-sector initiatives to promote organ, tissue, blood and blood stem cells donation, including enrolling in HRSA's Workplace Partnership for Life at organdonor.gov, and join thousands of other companies that are promoting donation in the workplace.

The issue of organ, tissue, blood and blood stem cells donation and transplantation reaches beyond the limited availability of these precious resources in the face of growing demand, but one issue is clear: By preserving the option of donation for all patients and families, one's choice to become a donor is honored and it provides hope for the many waiting for a transplant to save or heal their life. ACHE encourages its members to develop an environment that fosters this opportunity.

Approved by the Board of Governors of the American College of Healthcare Executives on November 10, 2014.

Related Resources

American College of Healthcare Executives Ethical Policy Statement, "Decisions Near the End of Life."

Health Resources and Services Administration
organdonor.gov
<http://bloodcell.transplant.hrsa.gov/>

Organ Donation and Transplantation Alliance
www.organdonationalliance.org

Donate Life America
www.donatelife.net

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