



Chief Executive Officer

A publication of the American College of Healthcare Executives CEO Circle

FALL 2020

COVID-19 and Healthcare Within the Correctional System

Samuel L. Soltis, PhD, LFACHE

Providing healthcare, in general, is a challenge within the U.S. correctional system, made even more complex with the onset of the novel coronavirus. Prisons across the country are prepared with emergency plans for disasters such as weather events, riots and other crises. When COVID-19 hit, establishing a preparedness, prevention and response plan was nothing new to the prison system; however, the potential rapid spread of a highly contagious virus poses a significant and different type of threat to an incarcerated population in a closed living environment.

Prisons across the country rapidly began to put in place plans to manage COVID-19 within their walls. As of Aug. 11, there were 95,398 inmates who tested positive for COVID-19 within state and federal prisons, according to the Marshall Project, a nonprofit news organization focused on the U.S. criminal justice system. Of that number, 62,102 inmates recovered, and at least 847 inmates died from COVID-19.

The South Carolina Department of Corrections is responsible for approximately 20,000 inmates in 21 institutions. Currently, SCDC has 1,127 COVID-19-related inmate cases and 12 inmates have died. Eleven of the deaths were inmates age 70 or older, and most had comorbid conditions, consistent with what the general population is experiencing. Beginning in February 2020, SCDC, with the assistance of community and governmental collaborators, began to identify, contain, manage and treat patients who had COVID-19. There have been many lessons learned throughout this process.

Initial Response and Action Plan

In 2016, the SCDC Medical Services Division put in place a formal infectious disease department consisting of a manager and two physicians who worked in coordination with the infectious disease department at the University of South Carolina Medical School. This department provided SCDC senior management with infectious disease information, such as the source and spread of infections, and offered mitigation strategies. An agency task force was created to work with experts in the field from the

(continued on Page 6)



LEADING WELL

Recruiting and Retaining Diverse Leaders

*Laura S. Kaiser, FACHE, and
Donna Padilla*

CEOs may not always appreciate the principal role they play in recruiting and retaining diverse candidates to their leadership teams. During an executive search, women, people of color and executives from other groups underrepresented in leadership pay very close attention to how the CEO behaves and prioritizes diversity in leadership. If a CEO emphasizes the importance of diversity hiring but there is no real organizational commitment or strategy behind it, candidates will know and seek employment elsewhere. Organizations hoping to attract a dynamic candidate pool will have their searches scuttled before they can even begin.

In our view, today's healthcare CEOs must take an intentional role in recruiting and retaining diverse leaders. This includes being more active and engaged during an executive recruitment and, more importantly, prioritizing diversity and inclusion in their organization and valuing

(continued on Page 5)



HEALTHCARE EXECUTIVE RESEARCH FINDINGS

Results provided by ACHE's Department of Executive Engagement, Research

Executives' Experience With Sexual Harassment in the Healthcare Workplace

The #MeToo movement has reopened the conversation about sexual harassment in workplaces. In late 2018, ACHE conducted the sixth in a series of studies comparing career attainments of women and men healthcare executives. ACHE has conducted these studies every five to six years since 1990. While containing many of the questions from the previous surveys, the 2018 questionnaire included more items asking respondents about their experiences with sexual harassment in the workplace. In all, 5,138 men and women members of ACHE received the 2018 study survey. Of those, 1,416 responded for an overall response rate of 28%.

Table 1 shows the proportions of men and women who reported in 2018 that they had experienced or witnessed workplace sexual harassment during the past five years. These questions were asked of a randomly selected half of respondents. The table also includes answers to these questions from previous studies. The proportions of men and women reporting having experienced or witnessed sexual harassment on the job were lowest in the 2006 and 2012 studies.

The other half of respondents were asked a more extensive set of questions about their experiences. Of those

surveyed, 83% of women and a higher proportion of men, 92%, said they would feel safe reporting an incident of sexual harassment to their employer. Of the 47 women and nine men in this half of the survey sample who reported having experienced sexual harassment in the workplace in the past five years, only about one-third, 17 women and two men, reported the incidents to their employers. Of those, almost half of the women (eight) and both men rated their satisfaction with how the incident was handled by the organization as 1 or 2 on a scale of 5, where 1 was "not at all satisfied" and 5 was "very satisfied." Common reasons for not reporting the incidents were: They did not feel the reports would be handled fairly by the organization, they were concerned about retaliation from the persons involved, they did not feel safe reporting the incident, they preferred to handle the situation on their own, they did not want the stigma of having made the report or felt it was not worth the effort, or the harassment was perpetrated by clients. These responses were made by small numbers of respondents and should be interpreted with some caution.

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

Table 1. The proportions of men and women who reported experiencing or witnessing workplace sexual harassment in the past five years. (Shading indicates years in which responses from men and women were significantly different, statistically.)

	1995		2000		2006		2012		2018	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Experienced sexual harassment	5%	29%	6%	23%	3%	10%	3%	13%	5%	17%
(n) ¹	(326)	(385)	(413)	(482)	(383)	(433)	(364)	(410)	(355)	(393)
Personally witnessed sexual harassment	not asked		24%	27%	11%	18%	10%	16%	14%	19%
(n) ¹			(415)	(479)	(382)	(434)	(363)	(410)	(353)	(391)

¹ Sample size



Advancing Gender Equity



Marna P. Borgstrom, FACHE, is CEO of Yale New Haven (Conn.) Health and Yale New Haven Hospital. Yale New Haven Health is the largest health system in the region and largest private

employer in the state. Borgstrom has served in these roles since 2005. Previously, she has held a variety of staff and operational roles at Yale New Haven Hospital.

Borgstrom is also chair of the board of the Healthcare Institute and serves on the boards of several other organizations, including the American Hospital Association, the Connecticut Hospital Association and New Haven Promise. She has been recognized for her commitment to community service and the healthcare field with numerous awards, and she holds five honorary doctorates.

Borgstrom earned a master's in public health from the Yale University School of Epidemiology and Public Health, where she currently lectures. She earned her bachelor's degree from Stanford University.

Yale New Haven Health is one of 13 healthcare systems from across the nation that are founding members of The Equity Collaborative, a membership-based program sponsored by The Carol Emmott Foundation. The goal of the collaborative is to move member institutions ahead more expeditiously, successfully and cost-effectively by learning from each other, and rigorously and transparently tracking progress. ACHE is working with The Equity Collaborative to amplify the work of the collaborative members.

What motivated Yale New Haven Health to join The Equity Collaborative?

YNHH has long been active in building awareness of the need for equity, measuring our performance and providing active support within the system to nurture it. Further, we believe that this is an important issue for our field. The ultimate reason for our participation in TEC relates to the great respect I have for Gayle L. Capozzalo, FACHE, executive director of TEC and former executive vice president and chief strategy officer at YNHH. (Capozzalo mentions TEC in a feature she co-authored for the fall 2018 issue of *Chief Executive Officer*, "Moving the Needle on Gender Equity in Healthcare Leadership" and in the Operational Advancements column she wrote for the Nov/Dec 2020 issue of *Healthcare Executive* magazine, "Healthcare's Equity Imperative.")

What has the collaborative achieved in its first year?

Perhaps the most important work has been bringing together leaders and different voices from across the healthcare field to try and define the issues and develop a common approach to making a meaningful difference. While this sounds like process, you can't actively develop a plan and make progress if the group doesn't share a common definition and vision. Going forward, I hope to learn from other organizations about strategies and tactics that have been effective and important to building sustainable gender equity.

Since joining the collaborative, how has YNHH advanced gender equity?

We have been trying for several years to advance open dialogue and measure our progress. As a result of our long-term interest and investment in equity, we have many women and people of color throughout our senior leadership team. During our next fiscal year, our system's eight business units will be led by a diverse team that consists of four women, including one of color; two Black men; and two white men. Most important, these are all extraordinarily accomplished leaders who work together well as a team.

What are key contributing factors to achieving gender equity at YNHH and in the healthcare field?

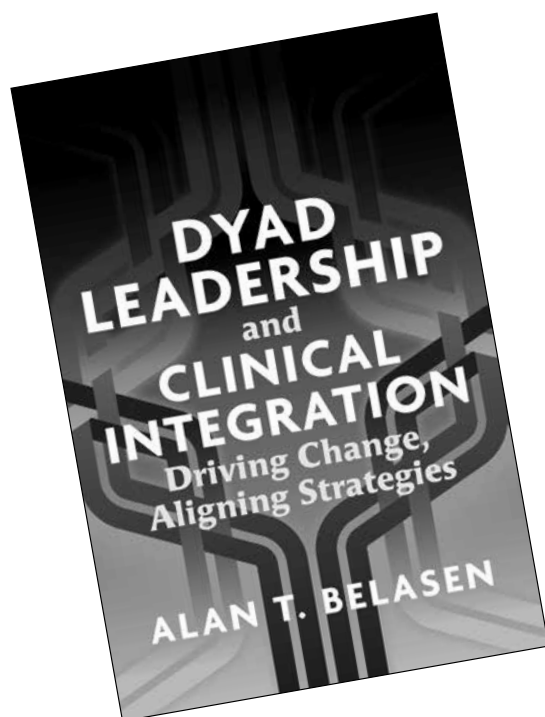
There are two key factors. The first is having universal recognition and agreement among leaders at all levels in our health system that gender equity is critical for our organization because it is good for patient care, a healthy work environment and business. The second factor is having career ladders for all promising leaders. These career ladders and personal development plans should not just focus on what people need to do to advance but on how they operate and can work most effectively as leaders and as members of a team.

How has ACHE supported advancing gender equity in healthcare?

ACHE offers a critical platform to continue to shine a light on the importance of this issue. By constantly including it among key leadership matters that require discussion, research and action, ACHE can continue to help advance gender equity in healthcare.



RECOMMENDED READING



Driving Change, Aligning Strategies

“In the upheaval of today’s healthcare system, with its push toward clinical integration, what leadership model will produce stability, even progress?” asks Alan T. Belasen, PhD, in the first chapter of *Dyad Leadership and Clinical Integration: Driving Change, Aligning Strategies*. In his book, Belasen, an experienced leadership development coach and consultant, synthesizes the expertise of academics, journalists and practitioners with assessments and concepts drawn from psychology, communications, organizational theory and management literature. He offers readers practical strategies based on a proven integrated framework, and he gives healthcare leaders the tools they need to establish and sustain exceptional partnerships between physicians and administrators.

ISBN: 978-1-64055-090-2

Softbound, 353 pages, 2019

Order code: 2385I

Member Price: \$40.60

Nonmember Price: \$58.00

ACHE Management



TREND TRACKER

Hospitals acquired by private equity firms are associated with larger increases in hospital-level economic measures as well as improvement in some quality measures after acquisition relative to nonacquired controls, according to findings from a recent study published in *JAMA Internal Medicine*. With private equity investment in healthcare on the rise in recent years, the study sought to find out if the acquisition of a hospital by a private equity firm is associated with changes in hospital income, use and quality. In an analysis of 204 private equity-acquired hospitals and 532 similar

hospitals that were not acquired by private equity, net income, charges, charge to cost ratio and the case mix index were found to differentially increase for private equity-acquired hospitals after acquisition relative to control hospitals. Additionally, some quality measures improved among a subset of private equity-acquired hospitals relative to the control group. For example, Medicare’s share of discharges decreased for private equity-acquired hospitals after acquisition relative to hospitals not acquired by private equity firms. <https://jamanetwork.com/journals/jamainternalmedicine>

People with Medicaid and exchange plan coverage are increasingly interested in and using digital and virtual health tools, according to findings from Deloitte’s 2020 Survey of U.S. Health Care Consumers and its Health Care Consumer Response to COVID-19 Survey. People in health insurance exchanges, compared with those who have employer coverage and Medicare, were most likely to shop for healthcare and use tools to look up costs. Roughly one-third of exchange consumers searched for information on drugs and healthcare service prices compared with 29% (drugs) and 27%

(healthcare services) of those with employer coverage. Exchange consumers were already the largest users of virtual care and showed strong interest in using new technology to manage their health before the pandemic. The surveys revealed that 45% of exchange enrollees use wearables for fitness, second only to the employer group, at 52%.

Consumers with Medicaid coverage also rely heavily on tech to engage with the healthcare system to manage their health. The surveys found that Medicaid enrollees (30%) are just as likely as those with employer coverage (31%) to say they use technology to monitor health issues, such as blood pressure. Additionally, people with Medicaid coverage are already among the most likely to have had a virtual

visit or consultation; approximately 25% had one of these visits in the last 12 months and another 10% had one in prior years. In 2020, the COVID-19 survey showed the highest use of virtual health among Medicaid consumers compared with other insured groups.

The 2020 Survey of U.S. Health Care Consumers sampled 4,522 adults from Feb. 24 through March 14, 2020. The Health Care Consumer Response to COVID-19 Survey was conducted in April 2020—at the peak of the pandemic—and queried 1,159 healthcare consumers to understand how consumers' attitudes and behaviors in managing their health and well-being were changing.

www.deloitte.com/us/en/insights/industry/health-plans

Recruiting and Retaining Diverse Leaders (continued from Page 1)

diversity in leadership as a guiding principle.

Walk the Walk

A CEO who values the importance of leadership diversity—where differing ideas and practices are shared by differing voices—creates a solid foundation for the successful recruiting of diverse leaders. A CEO who walks the walk will be able to answer yes to the following questions:

- Have I made it a stated priority that diversity in leadership is important to me and this organization?
- Have I fostered a culture where diversity and inclusion are

embraced by—and, increasingly, reflected in—the leadership team? Have I cultivated a culture in which differing views and values are welcome?

- Do I understand how to conduct a leadership search that maximizes the likelihood of hiring diverse candidates?

Women, minorities and other diverse candidates frequently inquire at the start of a recruitment process about the CEO's and organization's diversity and inclusion efforts. This often helps prospective employees determine their level of interest in the company.

Working with recruiters who have a great deal of experience with

(continued on Page 7)



You have the opportunity to impact the future of healthcare management.

Make a donation to the Fund for Healthcare Leadership to provide professional development scholarships for emerging healthcare leaders.

Visit ache.org/Fund to donate today.



CEO PURPOSE

Make a difference. Develop leaders with a common purpose to improve health. Share the knowledge resource you've come to rely on. When your management team joins ACHE, there's no telling how far you can take your organization.

Encourage your team to become part of ACHE.

[ache.org/Share](https://www.ache.org/Share)



American College of
Healthcare Executives
for leaders who care®

COVID-19 and Healthcare Within the Correctional System (continued from Page 1)

South Carolina governor's office, S.C. Department of Health and Environmental Control, the S.C. Emergency Management Division, and other state agencies. As a result, the following measures were implemented in mid-March 2020 to ensure the health and safety of inmates and staff:

- Suspending visitation and allowing inmates two calls a week to maintain social ties to family and friends. Nonmedically necessary inmate facility transfers; work release and labor crews; official staff travel; staff training and meetings; and volunteer visits were also suspended.
- Developing and implementing a screening tool for the front gates of each facility.
- Screening inmates at intake for COVID-19 symptoms and risk factors.
- Placing asymptomatic patients with exposure risk factors in a quarantined area, which is cleaned every two hours; vitals are taken twice a day for those with elevated temperatures.
- Placing symptomatic inmates with exposure risk factors in isolation and giving nurses in this area N95 face masks, gloves and gowns.
- Holding daily conference calls with wardens and healthcare authorities, such as head nurses, at each facility.
- Providing everyone with protective personal equipment, hand

sanitizer, face coverings and/or face shields.

- Having chaplains notify families of positive COVID-19 patients if there is a signed release of information.
- Conducting SCDC in-house inmate contact tracing.
- Testing inmates twice during the month preceding their release.
 - If an inmate tests positive, SCDC will attempt to keep the inmate past his or her release date unless the family can ensure it can quarantine the inmate.
 - If the inmate has nowhere to go for housing, DHEC is helping with placement in local hotels.
 - Inmates are given COVID-19 information, hand sanitizer and face masks upon release.

Cooperative Efforts

To protect the health and safety of inmates and staff, SCDC has collaborated with community and governmental agencies. Fortunately, SCDC has existing relationships with statewide hospital systems for inmate inpatient care when needed. One of the main providers of inmate inpatient care for SCDC is PRISMA Health in Columbia, S.C. The inmates receive the same treatments as the general public, i.e., ventilators if necessary, the use of plasma and remdesivir if the inmate qualifies for its use. PRISMA Health calls SCDC weekly to explore ways the health system can assist.

SCDC and the S.C. Department of Health and Environmental Control

(continued on Page 9)

diversity and inclusion can be vital to a search for diverse candidates.

Find the Right Search Partner

The CEO's role in attracting a diverse leadership team includes selecting the right search firm. Working with the head of talent management or human resources, the CEO is encouraged to ask probing questions to determine if a firm can attract a diverse candidate pool. These questions include:

- How diverse is your firm's workforce and leadership? Does the search firm also walk the walk?
- What is your track record of placing diverse candidates?
- How strong is your network and database for diverse leaders? With what pipeline of talent have you built relationships?
- What is your sourcing strategy to attract diverse candidates?

Build a Diverse Candidate Slate

Once recruitment gets underway, it is advantageous for the CEO and search firm to establish a clear expectation that the slate of candidates will be diverse, and all will be seriously considered for the role. No candidate should come away with the feeling of having been a token candidate.

It is incumbent on the CEO to challenge the search firm to provide a creative, thoughtful plan for finding the right candidates. Expect the search consultants to cast a much wider net than is done in a typical executive search. The recruiters may have to look farther and wider geographically, and they will need to

tap into key associations and organizations. When possible, they may also reach into other industries to secure interest.

A CEO who values the importance of leadership diversity—where differing ideas and practices are shared by differing voices—creates a solid foundation for the successful recruiting of diverse leaders.

Importantly, the CEO can play a part in initial outreach by making direct calls to colleagues in the industry, alerting them of an open position and soliciting nominations for potential candidates.

Evaluate Candidates Fairly

As candidates move through the interview process, it is helpful for CEOs to keep an open mind about how the next leader will appear and express himself or herself. Though the candidate certainly should align with organizational values, the CEO who is wary of hiring for culture fit or in the mold of the outgoing executive is better positioned to bring aboard diverse people.

One way to downplay a narrowly defined culture fit is to leverage executive assessments, which illuminate candidates' behavioral and

motivational tendencies and cognitive skills. Assessments act like the solid barriers used in orchestra auditions—they hide physical attributes and reveal the very things organizations need to succeed. The search firm should be able to provide these assessments themselves or via a trusted third party.

Another means of building fairness into the hiring process is to ask interviewers—the CEO included—to take unconscious bias training and bring increased awareness to the interview process.

Support Success in the Role

Once a hire is made, a critical factor in the candidate's success is the development of a comprehensive, meaningful onboarding program. (In the COVID-19 era, much of this program may be virtual.) A search firm can recommend an onboarding program that emphasizes the building of personal relationships as much as it does the nuts and bolts of the job.

Finally, CEOs would do well to view the hired executive as part of a new work family and community, and to take a personal, vested interest in their overall well-being and progress. The early signals the CEO sends in a new leader's tenure will contribute to their eventual success and to the organizational success that comes with having a dynamic leadership team with rich, broad perspectives and experiences.

Laura S. Kaiser, FACHE, is president/ CEO of SSM Health, St. Louis (laura.kaiser@ssmhealth.com). Donna Padilla is managing partner and leader of the Healthcare Practice at WittKieffer, Chicago (DonnaP@wittkieffer.com).

joined forces to conduct contact tracing, in accordance with Centers for Disease Control and Prevention guidelines, and placement of released inmates. SCDC is also working with DHEC to effectively obtain and distribute a vaccine within the prison system once one becomes available.

Furthermore, SCDC has partnered with the S.C. National Guard to provide staff assistance in facilities with staff shortages; the S.C. National Guard takes inmates' vital signs twice a day in these facilities. SCDC is also working with the Medical University of South Carolina to provide telehealth and conduct targeted testing. Currently there is a 7- to 10-day turnaround time due to testing volume.

The local county jails are working with SCDC to hold as many convicted inmates as possible in their facilities rather than releasing them to SCDC and increasing the chance of spreading the virus into the prison system at a time when containment measures are underway. This effort has resulted in a lack of capacity and availability of medical services at the county jails. Some inmates awaiting trial are being released from county jails, and court cases, which are backlogged, are being scaled back. In addition, jury trials

are canceled when people need to be physically present. These measures may have a negative impact on the health and safety of the community.

Lessons Learned

Providing medical care in a prison system presents unique challenges; however, there is crossover to healthcare services provided outside of the prison system. For example, nursing and ancillary staff shortages are occurring in both prison and hospital systems. A contingency plan and personnel cross-training is crucial in times of disasters. Like many healthcare institutions, SCDC tends to work in silos, but both systems are learning new ways to work together for the good of the whole. For example, one or both systems are taking the following actions:

- Embracing telehealth for inmate treatment, particularly in specialty services such as psychiatry.
- Opening satellite specialty services to localize care and decrease inmate transports.
- Decreasing staff and inmate movement and interaction. Currently, there are more than 100 staff-to-inmate contacts a day for various reasons.

- Developing back-up plans when staff or inmates cannot be used for such activities as food preparation and cleaning.
- Using video visitation throughout the prison system to offset a decline in inmate morale due to the lack of socialization, and making exceptions to the rules when necessary, i.e., allowing use of video chat and hand sanitizer, despite its alcohol content.

This pandemic has taught and continues to teach healthcare and prison systems alike about the need to adjust to extraordinary times. Some changes may be difficult but necessary and could possibly set the stage for innovative and efficient ways to provide medical and mental healthcare in the future.

Samuel L. Soltis, PhD, LFACHE, is the ACHE liaison to the National Commission on Correctional Health Care, Chicago, and he is based in Venice, Fla. (samuelsoltis@bellsouth.net). A Certified Correctional Healthcare Professional, he previously served as deputy director, health services, South Carolina Department of Corrections; director, health services, South Carolina Department of Juvenile Justice; and in various healthcare administration and operations roles.



American College of
Healthcare Executives
for leaders who care®

Chief Executive Officer

© 2020

Editor

Lea Radick

Designer

Carla Nessa

American College of Healthcare Executives
Fall 2020: Volume 26, Issue 4

Published four times a year for members of the American College of Healthcare Executives CEO Circle. The CEO Circle annual membership fee is \$300.

CEO Circle membership is open to all ACHE members who are CEOs or the equivalent.

To learn more about the benefits of becoming a CEO Circle member or to subscribe to Chief Executive Officer, call (312) 424-2800 and ask for a CEO Circle representative, or visit ache.org/CEOCircle for more information.



Chief Executive Officer is brought to you in part by the support of Roche Diagnostics Corporation, an ACHE Premier Corporate Partner. For more information, please visit diagnostics.roche.com.