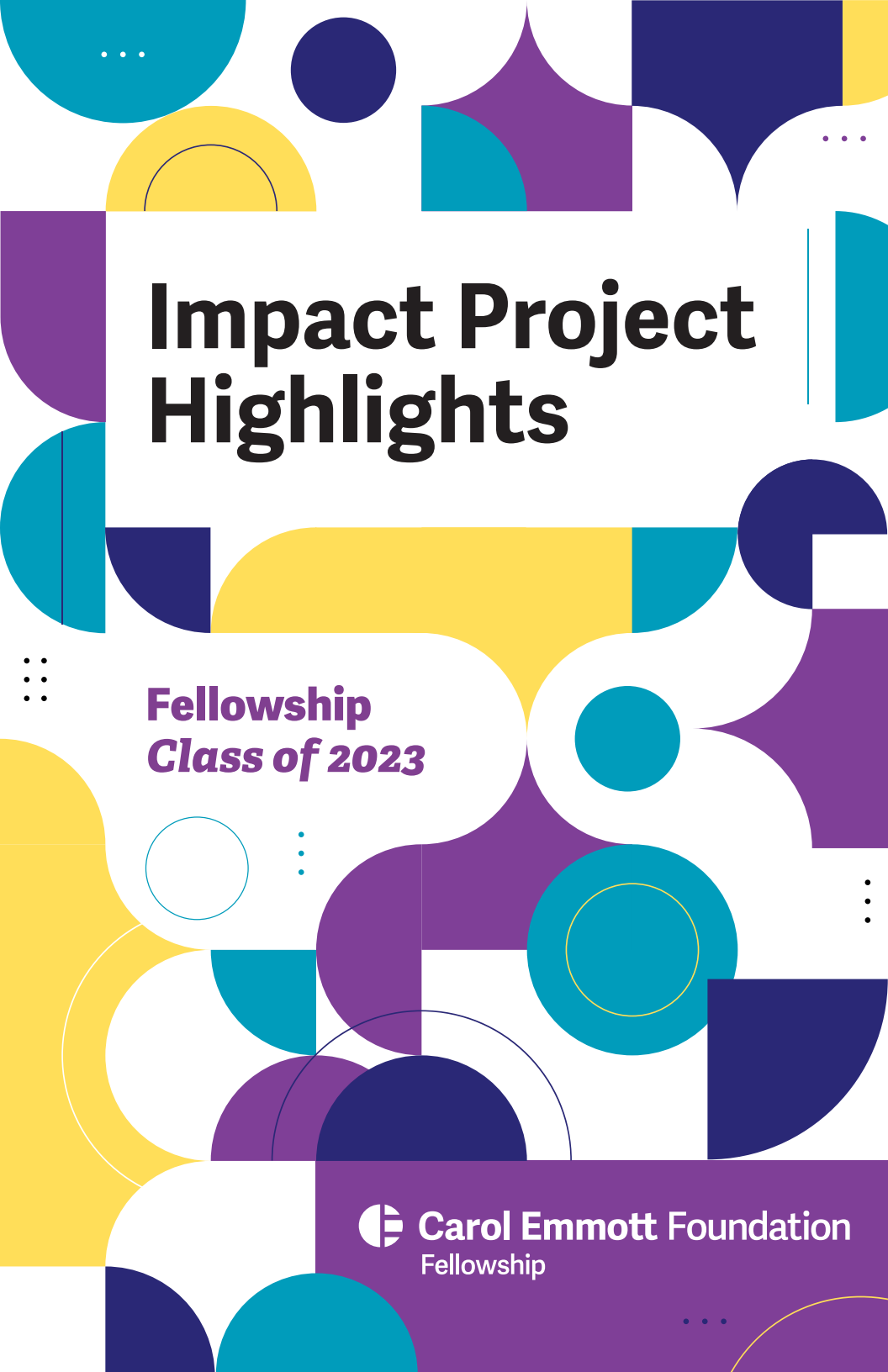




Impact Project Highlights

Fellowship
Class of 2023



Carol Emmott Foundation
Fellowship

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Committed to Making an Impact in Healthcare

The Carol Emmott Foundation is dedicated to accelerating gender equity and diversity in healthcare leadership and governance by connecting a powerful network of women, allies, and organizations. Changing the *face* of healthcare and creating a robust community that is aligned to do so is our true north.

Every year, the Carol Emmott Fellowship expands its reach by bringing together women who are leading healthcare systems across the country. The program provides them with access to senior executives in the top tiers of healthcare as well as a national platform to share their thought leadership. Nominated by their institution, fellows must be inspirational and compassionate leaders committed to making a significant impact in the field.

The 2023 cohort of 21 women was our most diverse group to date and included three Foundation-sponsored fellows. Over the course of the Fellowship journey, fellows designed and led an impact project at their institutions. Projects focused on enhancing the overall wellbeing of the community that the institution served and was outside of the fellow's day-to-day role and responsibilities. The 2023 projects illustrate the dedication of these remarkable women to influence strategy and drive outcomes that will positively transform healthcare.

“A fundamental concern for others in our individual and community lives would go a long way in making the world the better place we so passionately dreamt of.”

Nelson Mandela



Sarah Johnson Conway, MD

Interim JHM Senior Vice President,
Office of Johns Hopkins Physicians; Chief
Medical Officer, Johns Hopkins Clinical
Alliance; Assistant Professor of Medicine

JOHNS HOPKINS MEDICINE

Dr. Sarah Johnson Conway is the interim Senior Vice President of the Office of Johns Hopkins Physicians, responsible for developing the strategy for the clinical practice of employed and affiliated physicians and assisting in the development and execution of the strategy for the overall clinical enterprise. She oversees ambulatory operations, patient access, physician alignment and integration, digital health, and the physician/practice strategic learning center.

Partnering to Improve Care for the Underserved

Johns Hopkins Medicine (JHM) has a core commitment to caring for its local community, which includes a traditionally underserved patient population. To support this critical mission, JHM values strategic partnerships with Federally Qualified Health Centers (FQHCs) which provide care to all patients along with enhanced wraparound resources. A collaborative model with an Academic Medical Center allows for an enhanced, high quality, and sustainable model of primary care linked to a shared mission of caring for the community.

Dr. Conway led the partnership development with a large FQHC partner in Baltimore which was opening a new community health center across from their Bayview Hospital. Dr. Conway led the successful transition of pediatric and OB/GYN services from the hospital campus to the new community health center. This partnership allowed for much needed expansion of those service lines and the addition of new, co-located critical supports including behavioral health, dental services, and enhanced community and coverage navigation. Through this unique collaboration, clinical care continues to be provided by Johns Hopkins Medicine employed physicians, and the center is a vibrant location for community-based research and education of the next generation of clinicians dedicated to care of high need communities.



Poonam Desai, MHA

Executive Director – Ambulatory Operations, Community Health and Hospital Division

UCHICAGO MEDICINE

Poonam Desai is the Executive Director of Ambulatory Operations at UChicago Medicine. In this role she oversees clinic operations for the UChicago Medicine Medical Group and ambulatory programs for the community based hospital as well as practice and physician integration efforts across the Ambulatory system.

Addressing Challenges of a Growing Health System: Bringing Standardization to New Site Activations

UChicago Medicine's clinical enterprise currently includes more than 13,000 employees working across four Inpatient Facilities and 17 Ambulatory Care sites across the Chicagoland region. It is poised for continued growth into new markets. As the health system expanded across state lines and into the western Chicago suburbs, it became clear that the process for opening and activating new clinic sites varied from project to project, leading to delays and inefficiencies.

To streamline efforts for efficiently activating new clinics, Poonam Desai brought together key stakeholders from the Medical Center and Medical Group and assembled a multidisciplinary team including representation from the IT, Facilities, Supply Chain, Human Resources, the Medical Staff, and Operations to develop an Integration and Activation playbook. She used this playbook to lead the acquisition and integration of a Podiatry practice into the UChicago Medicine portfolio.

Her leadership on this project helped break down silos across the multiple entities and departments as well as brought clarity and transparency to process ownership. These efforts have led to the establishment of the UChicago Medicine Integration Management Office that is comprised of Strategy, Operations, and Performance Excellence leaders who now oversee all new clinic and site activations.



Loretta Erhunmwunsee, MD

Associate Professor, Division of Thoracic Surgery and Division of Health Equities

CITY OF HOPE

Dr. Loretta Erhunmwunsee is an Associate Professor in the divisions of thoracic surgery and health equity at City of Hope. She conducts research that evaluates the impact of structural racism and other adverse social determinants on lung cancer outcomes with a goal of reducing healthcare disparities.

Assessing and Addressing Social Determinants of Health

Racial and ethnic minorities and individuals with low socioeconomic status experience considerable cancer health disparities. These inequities are often the consequence of adverse social determinants of health – the conditions in which people are born, work, play, and live – that vulnerable groups disproportionately endure. Despite the fact that social determinants strongly influence health outcomes, there is a lack of consistent measurement of these conditions and therefore little support provided to vulnerable patients to ameliorate these conditions.

To address this problem, Dr. Erhunmwunsee co-developed a Social Determinants of Health Working Group, which includes stakeholders from across the enterprise, including nursing, community benefits, IT, new patient services, surgery, social work, supportive care, network site leadership, and community outreach. The group successfully created an enterprise-wide workflow for assessing patient social determinants within four distinct domains, namely financial need, transportation, housing, and food insecurity through an electronic medical record build. Additionally, the group created pathways for linking patients with identified needs to supportive services within the region, by leveraging nursing, case manager, social work teams, and community organizations. QR codes for accessing community services were added to each patient's visit summary. Inpatients who are food insecure are given the opportunity to order a non-perishable bag of food at no charge at discharge and are connected to community services. There are a critical number of individuals who have significant needs that now can be addressed, resulting in improved patient health.



Jacquelyn Frombach, DNP, RN

System Chief Nurse Executive

MARSHFIELD CLINIC HEALTH SYSTEM

Jacquelyn Frombach, System Chief Nursing Executive for Marshfield Clinic Health System, has over 20 years of nursing leadership experience in both the acute and ambulatory practice settings. She has expertise in leading efforts to engage the nursing workforce in all areas of the care continuum to identify best practices and foster innovation and change that supports the profession of nursing.

Nursing Health Information Technology Governance

Elevating the nursing voice and expertise of frontline nursing professionals is key in driving improvements in care delivery efficiency, clinical outcomes, staff engagement, and retention. This is also a key priority as healthcare faces challenges with nursing workforce shortages. Dr. Frombach's impact project focused on formalizing a system Nursing Governance structure incorporating nursing input and decisions on the use of information technology to support the delivery of safe, effective, and efficient clinical care within the Marshfield Clinic Health System. This project was successful by securing support and endorsement of the governance structure from all levels of the organization, clearly demonstrating the value of the nursing professional voice. This has led to moving decisions forward in the use of technology in care delivery, workflows, and policies from the nursing expertise perspective. This approach also serves as a foundation to expand Shared Decision Making and fostering the ongoing growth of nursing professionals and healthcare leaders of the future who will continue to focus on high quality care delivery for the rural communities Marshfield Clinic Health system serves.



Andrea Gibson

Chief Strategy Officer

COOK COUNTY HEALTH

Andrea Gibson is the Chief Strategy Officer at Cook County Health, the largest safety net health system in Cook County, Illinois, and the largest Medicaid Managed Care Plan, CountyCare.

Provider/Plan Alignment Strategy for Integration and Sustainability

Cook County Health (CCH) is the largest safety net health system as well as home to the largest Medicaid Managed Care plan in Cook County, IL. Historically only a small percentage of the CountyCare membership gets their care at CCH despite significant member demand and need for services. Having both the provider of healthcare and the health plan in one organization provides a unique opportunity to integrate the two and improve health outcomes and financial sustainability.

Andrea Gibson convened and led a multi-departmental workgroup of 20 people to create a workgroup, establish targets, measure progress against those targets, and work through the programmatic changes or initiatives identified to meet the revenue and quality goals. Some of the initiatives included an outreach campaign to empaneled members who were not currently in care, process improvements to reduce wait time for certain specialties, reducing external pharmacy costs by leveraging 340b discounts, and establishing an Emergency Room navigator to make follow up appointments for CountyCare members. Through this workgroup the organization was able to get more CountyCare members into care and remove obstacles to access. As a result, CCH has surpassed the revenue targets, increased the percentage of empaneled members in care, improved HEDIS metrics, and reduced the wait time for CountyCare patients seeking care. This foundation will be used as a basis to set more challenging goals in the coming year.



**Laura Hendricks, DNP,
NEA-BC, RN-BC, CPHQ**

VP of Patient Care Services and Chief
Nursing Officer, Sibley Memorial Hospital

JOHNS HOPKINS HEALTH SYSTEM

Dr. Laura Hendricks is a healthcare executive with over 20 years of experience and expertise in an array of areas, including the acute care setting, academic setting, and the community and public sectors. She is the Vice President for Patient Care Services and Chief Nursing Officer at Sibley Memorial Hospital/ Johns Hopkins Medicine and oversees a team of dedicated leaders with a goal of influencing both patient and staff outcomes.

Using Innovation to Enhance the Recruitment and Retention of Nurses

Despite being the largest healthcare profession in the country with over 4.2 million registered nurses, the U.S. healthcare system continues to be hampered by a nurse shortage. Prior to the pandemic, the shortage was at the forefront of our professional agenda; this issue has now reached a tipping point. Hospitals have no choice but to take proactive measures to tackle what has been declared a national crisis.

To address this crisis, Dr. Hendricks developed an innovative “bridge program” for student nurses to provide pre-licensure transition support and prepare a pipeline of qualified student nurse applicants for Sibley Memorial Hospital/Johns Hopkins Medicine. The one-year program offers a realistic practice environment for students and builds resilience through intentional organizational enculturation approaches while supporting nursing students during their final clinical practicum. The program engages nurse leaders from the clinical and academic settings and creates a formal partnership while offering wrap around support for student nurses. It creates a seamless path to RN licensure and pre-licensure employment. Supports embedded into this program include financial, coaching, mentorship opportunities, resiliency support, practicum placement, and organization enculturation experiences. During its first year the program extended scholarships and employment to over ten student nurses. Dr. Hendricks and her team are committed to scaling the program and removing barriers to employment.



Jessica Johnson, MHA

Chief Operating Officer – Charleston

MEDICAL UNIVERSITY OF SOUTH
CAROLINA HEALTH SYSTEM

Jessica M. Johnson currently serves as the Chief Operating Officer at the Medical University of South Carolina (MUSC) – Charleston Division. She leads the strategic and day to day operations of the state’s only tertiary and quaternary care organization, directly supporting peri-operative, therapeutic, and ancillary teams through the system.

Leveraging The Power of Community to Prevent Violence in Healthcare Delivery Setting

Across the country, the rate of acts of violence have rapidly increased over the last few decades. Unfortunately, violence within healthcare delivery settings follows a similar trend. Even more notable is that the increase is driven by both colleague to colleague and patient/visitor to care team incidents. Recognizing the cause and exacerbation of these events are multi-factorial, the organization is leveraging a multi-disciplinary approach to address the root causes driving violent behavior. Jessica Johnson assembled a group of key internal and external stakeholders to sit on both a specialty workgroup and steering committee. The goals within the first year are to implement the following: 1) a robust mental wellness program for healthcare workers, 2) patient family advisory council integration within hospital strategy, 3) a violence assessment tool for patients and visitors, 4) a training and education program to promote improved de-escalation and event preparedness in ED, IP, and OP settings, and 5) community events with local police departments, community advocates, and violence survivors. To date, the project is on track to achieve all goals for the first fiscal year of programming, with the aim of expanding programming to regional health network and university colleagues, learners, and visitors.



Sarah Johnson, MBA

Chief Operating Officer, Penn Medicine at Home

UNIVERSITY OF PENNSYLVANIA
HEALTH SYSTEM

Sarah Johnson has decades of experience in Human Resources and healthcare operations and leads strategy and business development at Penn Medicine at Home to expand care to patients in the home across the organization's vast geography in Pennsylvania and New Jersey. Penn Medicine at Home currently has an average daily census of over 7,000 patients and provides over 700,000 home visits to patients annually.

Penn Medicine at Home Provides Advancing Care in the Home to Patients

In partnership with Penn Medicine at Home and the Penn Medicine Medical group, Sarah Johnson led the creation of the infrastructure for home based Physicians and Advanced Practice providers to care for patients in their homes. Penn Home Providers is a geographically diverse group of providers who offer care for multiple specialties with one centralized infrastructure for the clinical departments and hospitals to include a visiting provider as part of the care team and to extend care pathways to the home. The virtual practice infrastructure includes a practice manager, medical assistants, social work, and nursing to ensure that providers in the home are working at top of license and that the patients have the full services of a physician practice. To date, the team has successfully partnered with primary care, nephrology, and palliative care along with Penn Medicine at Home traditional programs such as Home Health and the Community Health Workers. The team will next focus on home visits for newly discharged Sepsis patients and discharge to home from the Emergency Departments to prevent further ED visits and readmissions while allowing patients to recover at home



Fran Maddox

Senior Vice President, Spend Management Delivery

VIZIENT, INC.

Fran is the Senior Vice President of Spend Management at Vizient. She has more than 20 years in helping healthcare organizations in their cost performance improvement.

Building Healthy Communities

In partnership with the Child Care Group (CCG), utilizing Vizient's Vulnerability Index, Fran Maddox and team will help expand the work CCG currently does to educate and promote healthy communities. The index helps determine if the community is being influenced by factors such as food insecurities, lack of transportation and/or chronic health issues like diabetes, hypertension, and heart disease. Through community outreach in the form of health fairs, partnering with local healthcare providers, the team is aligning the focus by zip code to promote education of children and their parents on the health problems most likely influencing their lives. The ultimate goal is education and access to resources that help these communities live healthier lives.

“For me, the passion and dedication with which I serve defines who I am, not just what I do. It is the force that drives me to demonstrate authentic leadership, and the same passion with which I live my life, and in turn, build a sustainable team culture of high performance and trust.”

Laura Hendricks, Carol Emmott Fellow



Katie McKittrick

Chief of Staff, Office of the SVP & CHRO
at Duke University Health System

DUKE HEALTH

Katie McKittrick serves as Chief of Staff for Duke University Health System's Senior Vice President and CHRO, delivering on the strategic human capital priorities that drive the mission of the clinical enterprise. Her passion is creating and sustaining workplaces where everyone feels seen, heard, and valued, and is empowered to give their very best.

Transforming HR: Building a TalentForce Function for Today's Workforce

Healthcare's workforce is requiring a new deal. Beyond the disruption and unprecedented burnout prompted by a global pandemic, retention is proving to be more difficult than ever as new industry entrants, a return to purpose and five generations under one roof all put pressure on how organizations deliver a remarkable employee experience.

Supporting this new deal and successfully retaining top talent requires an HR service delivery model that meets the changing and unique demands of healthcare. Katie McKittrick is part of the team leading Duke's HR Transformation (HRT), which kicked off in 2023 as the organization continued efforts to recalibrate and stabilize in a post-pandemic world. The HRT is a multi-year effort that will redesign and rebuild the organization's foundational and transactional HR infrastructure and supporting business partner model. Additionally, the HRT will focus on creating progressive centers of excellence that will help differentiate Duke as an unparalleled place to work while growing careers that matter.



**Robin Menefee RN, BSN,
MBA**

Regional Director of Operations

SUTTER HEALTH

Robin Menefee is an Area Director of Operations with over 20 years of experience in Surgical Services leadership, a career that began when she served in the U.S. Air Force. Over the years she has served as a servant leader who puts the needs of her team first and engages the physicians and patients in her sphere of influence in ways that show she cares about them.

**Connecting Isolated Demographics to Reduce Loneliness
in Our Communities**

In 2023, one in three adults aged 50-80 (34%) reported feeling isolated from others. Since COVID, studies show a trend of Americans becoming lonelier. Screen time is a key driver causing higher levels of social isolation for the mature and the young. Loneliness has been linked to mental health issues such as anxiety and depression. Feelings of isolation can negatively impact physical health.

Robin Menefee's project focused on connecting mature adults to teens and young adults so they could learn from each other with a goal of forming meaningful relationships. She continues to collaborate with local leaders in the community to create the space to bring these two groups together for meaningful exchanges.



**Melissa A. Ortega, PharmD,
MS, FASHP, FACHE**

System Vice President, Ambulatory
Pharmacy Services

TUFTS MEDICINE

Melissa Ortega is a transformational leader committed to providing exceptional patient care and improving healthcare services. She has improved the healthcare delivery model by championing the advancement of pharmacy practice and programs across the care continuum and currently leads pharmacy operational and clinical integration initiatives for specialty, home infusion, retail, virtual, and ambulatory pharmacy services.

**Establishing Partnerships to Build the Healthcare Workforce
of the Future**

High vacancy rates strain healthcare processes and programs, and therefore, workforce challenges such as shortages, retention, and staff burnout ranked among the top issues and concerns for health systems CEOs, including Tufts Medicine. A need was identified to address present and future workforce needs at Tufts Medicine by placing a strong focus on seeking academic partnerships with which Tufts Medicine can engage in creative problem-solving. Melissa Ortega led efforts in establishing the scope of the partnership, the executive steering committee, assembling the work streams, and gathering team members. An initial focus was placed on the nursing profession with the intent that the outcomes and learnings of this project will serve as a framework for other healthcare professionals within the health system, such as pharmacists and respiratory therapists. Successes to date include an established partnership, executive leadership commitment, investment of resources, and established workstreams to create innovative solutions to address critical workforce challenges, align academic and practice needs, and explore alternative practice and training models.



Kiren Rizvi Jafry, MPA

Vice President Operations Integration

SUTTER HEALTH

Kiren Rizvi Jafry is the Vice President of Operations Integration at Sutter Health and has served in multiple leadership positions with the integrated health system over the last 15 years. She focuses on the integration of people, processes, and technology, spanning clinical programs, business systems, and health services from a strategic and operational lens.

Outpatient Specialty Practice Referral Optimization

Kiren Rizvi Jafry led a referral optimization initiative across the Sutter Health system to improve access for patients seeking specialty care. Experiments were conducted within the Orthopedic service line. She partnered with orthopedists in six medical groups (representing 174 clinicians), system administrators, 37 care teams, and the digital health team to design a suite of solutions that improved days to schedule an appointment and enhanced digital enablement for patients.

The cross-functional teams focused on multiple levers: 1) centralization of referral processing to one number, 2) reduction of visit types, and 3) development of decision tree algorithms for scheduling staff and patients. Early experimentation of a centralized number resulted in a 69% improvement rate to process referrals (13 days to 4 days). The team also reduced the number of scheduling visit types across affiliates by 24%. Currently, the focus is on decision trees based on body parts to simplify scheduling rules. There are over 1300 scheduling rules across the orthopedic practices today. The goal is to enable patient self-scheduling by 80% and to simplify scheduling rules for admin staff. Decision trees will be available within the EMR platform and the system's patient-facing mobile app.



Adia K. Ross, MD, MHA

Chief Medical Officer, Duke Regional Hospital;
Asst. Professor of Medicine, Division of
Hospital Medicine; Faculty Advisor

DUKE HEALTH

Dr. Adia K. Ross is the Chief Medical Officer at Duke Regional Hospital and Associate Professor of Medicine at Duke School of Medicine, overseeing diverse responsibilities such as medical education, provider clinical practice, quality and safety, and nutrition services. She serves as the service line executive for heart/vascular services and oncology at her hospital and remains a practicing hospitalist.

Re-designing Heart and Vascular Services to Meet the Needs of the Community

Dr. Adia Ross led a team to optimize and expand surgical services, enhancing access to care for underserved communities. During this initiative, she analyzed current surgical offerings, collaborated with the Duke Health Surgeon in Chief, and assessed Duke's Vizient performance to identify potential areas for improvement. Analysis revealed a higher rate of amputations in the surrounding communities compared to peer groups.

This complex issue requires a multifaceted approach, including proactive patient identification, enhanced patient engagement, and population health management strategies. This prompted further initiatives to redesign and redistribute resources within the heart and vascular service line to address the underlying causes of this disparity. A multidisciplinary group comprising population health practitioners, vascular surgery, interventional cardiology, nursing, and podiatric services was formed to work collaboratively to identify specific subpopulations and design targeted interventions. The team also re-examined the administrative support structure to include new roles to help coordinate the work. The team decided to focus on patients with a known history of peripheral vascular disease, recent lower extremity amputation, and/or poorly controlled diabetes with a foot deformity.

A review board has been established using clinical data analysis tools to identify patients with these three conditions and collaborate with the primary care providers to discuss clinical guidelines and encourage timely referrals.



**Caroline Sarratt Russell,
MSHA, FACHE**

Associate Administrator

MAYO CLINIC – FLORIDA

Caroline Sarratt Russell is the senior administrator for the Department of Surgery, Surgical Specialties, and the Department of Transplant for Mayo Clinic in Florida, responsible for strategic and operational oversight of 14 surgical departments and divisions, including anesthesia and transplant. She also serves as the administrative lead for Mayo Clinic in Florida's Clinical Practice Shield, leading strategies and operational initiatives to support clinical practice priorities for the Florida campus.

Transforming Healthcare Through Learner-Led Community Clinics

Mayo Clinic in Florida serves as a premier healthcare destination for patients traveling from all 50 states and almost 90 countries. Caroline Sarratt Russell influences and directs numerous organizational priorities that impact patients travelling many miles to seek care. At the same time, she supports local community needs and is helping to ensure the training ground is built to support future generations of top talent healthcare providers. To help meet these goals, Sarratt Russell established a learner-led, community-focused, outreach clinic in partnership with a community-based non-profit organization supporting an underserved patient population. The outreach clinic was designed as a sustainable expansion to an existing community health agency and provides a focal point for increased community outreach and impact.

Access to healthcare is a significant barrier for under-resourced communities in Jacksonville, Florida, and contributes to poor health outcomes and health disparities, according to the 2022 Community Health Needs Assessment (CHNA). The newly established clinic strives to address inequities in healthcare access. This initiative also increases opportunities for learners and staff to serve a varied patient population and increases learners' understanding of community health needs. The clinic links learners, community healthcare professionals, and community-based organizations to address disparities and support health equity.



S. Monica Soni, MD

Chief Medical Officer and Chief Deputy
Executive Director

COVERED CALIFORNIA

Associate Professor at the University of
California, Los Angeles and Charles R.
Drew University of Medicine and Science

Dr. S. Monica Soni is a board-certified practicing Internal Medicine physician who works at the nexus of population health, social justice, and health system affordability. An agitator for change and stickler for clinical excellence, Monica has worked in quality, operations, and value-based care in both the public and private sectors.

Accountability for Health Equity at Scale

Covered California, the State-Based Marketplace, serves approximately 1.7 million Californians. Since its inception Covered California has maintained the same mission: to increase the number of insured Californians, improve healthcare quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. The focus on health equity runs through every part of the organization from the marketing and outreach strategy to patient-centered benefit designs to contractual requirements on demographic data collection and disparities reduction interventions.

Covered California's Equity and Quality Transformation (EQT) Division, led by Dr. S. Monica Soni, has proposed a bold, groundbreaking Health Equity methodology. The methodology goes beyond solely stratifying quality measures by race and ethnicity and adds meaningful financial incentives to health plan performance. However, rather than historically used methods of comparing a lower performing racial/ethnic group to a higher performing racial/ethnic group (often the white subpopulation), the approach compares each subpopulation performance to a national benchmark. This embraces excellence for all as the standard rather than promoting marginal, but still suboptimal, improvement. Covered California's Health Equity methodology anchors on the principle that there is no quality without equity in pursuit of health for Californians.



Maureen Stevenson, MD

SVP, JMH Foundation Practice Operations

JOHN MUIR HEALTH

Dr. Maureen Stevenson is an Internal Medicine physician and presently serves as the SVP of John Muir Foundation Practice Operations since 2021. In her role she oversees the ambulatory operations for John Muir Health's Primary Care, Pediatrics, Urgent Care, Cardiology, Multispecialty, and Medical Oncology practices.

Care Across the Continuum

Congestive Heart Failure is increasing in the United States, especially as our population ages. The economic impact from CHF admissions is significant, at an estimated \$35 billion in direct costs annually for these admissions. Many of these admissions are avoidable with ambulatory interventions including but not limited to ambulatory diuresis. The cost of these avoidable admissions is not just financial as each admission puts the patients at risk of acquiring Hospital Acquired Complications. To address this issue in our organization, Dr. Stevenson convened a cross continuum group consisting of Emergency Physicians, Urgent Care, Cardiologists, Hospitalists, Primary Care Physicians, CHF Navigators, the CMO, the Cardiology Service Line Executive, Population Health, Ambulatory Operations, and Informatics. In the meetings it was clear that if the providers had other options than admission, their preference would be to discharge the patients back to their home setting. After achieving buy-in from multiple stakeholders Dr. Stevenson worked with Cardiology to address the need from a cross continuum clinical pathway. While the pathway was being developed and rolled out, she worked with the other stakeholders to begin to operationalize space in one of the Urgent Care. This will enable appropriate patients to be seen 7 days /week, 365 days/year in the ambulatory setting. The group is working towards the first patient being seen in late January/early February. If the desired outcomes are achieved, the group will begin to address additionally avoidable admissions such as COPD (Chronic Obstructive Pulmonary Disease).



Denise Torres, MD, FACS

Chair, Surgery Institute & Dept of General Surgery

GEISINGER HEALTH

Dr. Denise Torres is the Chair of the Surgery Institute at Geisinger as well as the Chair of the Department of General Surgery. She is a trauma and acute care surgeon and is responsible for overseeing more than 140 surgeons throughout the health system.

Caring for the Caregiver

Adverse outcomes are an unfortunate and inevitable part of surgery. When they occur, many people suffer, including the care team. While the patient and their family are the focus after these events, Surgeons and other care teams can be emotionally traumatized from the event, leading to "Second-victim Syndrome." If this is left untreated it can adversely affect people physically and emotionally, which could ultimately affect future patients.

Dr. Torres implemented a second victim program for the Surgery Institute at Geisinger. A process was developed when adverse events were identified, for trained surgeons to reach out to the individuals involved to make sure that they had the support that they needed. An onboarding program was also developed for all new surgeons to be paired with a different subspecialty surgeon to help them acclimate to Geisinger.



Stephanie D. Willding, MPA

CEO

COMMUNITYHEALTH

Stephanie D. Willding is a healthcare executive with more than 15 years serving under-resourced communities. She is currently the CEO of CommunityHealth, the nation's largest volunteer-based free health center, where she is committed to rebuilding systems that engage and empower under-resourced communities to lead healthier lives.

Rethinking Space and Place for Point of Care: Expanding Community-Based Micro Health Centers

For uninsured communities in Chicago, it is not uncommon for patients to take several buses to access affordable, high-quality health care. CommunityHealth, the nation's largest volunteer-based free health center, is working to change this experience by bringing health care to the neighborhoods where these patients live and work. As CEO, Steph Willding convened partners, secured funding and resources, and empowered a skilled team to open its first micro health center in 2021. This location is around 1,000 square feet and a place where patients can receive in-person and virtual primary care, lab services and medication pick-up. This health center is co-located within a community-based organization, ensuring that patients also have direct access to food assistance, childcare, legal assistance, and more. Through co-location and the micro size of the health center, these locations are both sustainable and scalable. Opening a second micro health center in 2022, CommunityHealth is primed to continue expanding this model to place more doors in the communities that need them most. In 2023, over \$1.75 million has been secured, allowing CommunityHealth to bring health care to more people over the next two years



Deremius Y. Williams, MPA

Senior Vice President, Payer Strategy
and Innovation

YALE NEW HAVEN HEALTH

Deremius Y. Williams is the Senior Vice President of Payer Strategy and Innovation at Yale New Haven Health. In this capacity she is responsible for leading the development, communication and realization of system-wide strategies for payer contracting, payer relations, employer engagement and strategic program development across fee for service, value-based care and alternative payment models.

Advancing a Collaborative Medicare Advantage Strategy

Medicare Advantage is the fastest growing insured population in the state of Connecticut. Further, the age distribution of the population is rapidly increasing towards higher age bands, producing significant increments of new Medicare eligible individuals yearly. These dynamics suggest continued outpacing growth in the Medicare Advantage population in the state for some years to come. Deremius Williams is leading the development and execution of the organization's Medicare Advantage Payer Strategy with a focus on collaborative partnerships that involve multidisciplinary leadership in accountability, engagement of physicians in design and favorable model constructs in alignment with the organization's vision and mission.

The strategic focus on Medicare Advantage has involved appropriate identification and engagement of key stakeholders whose alignment is critical to creating organizational momentum, and to operationalizing the tools, capabilities, and processes necessary to achieve impactful goals. Williams's work to date has created a strong foundation from which to build whereby success will signal that we have recalibrated the model of accountability and shifted our healthcare landscape in a manner that produces tangible and sustainable value for our patients and providers.



Christine Yang, CHCIO

VP/Chief Technology Officer

ALAMEDA HEALTH SYSTEM

Christine Yang is the VP and Chief Technology Officer at Alameda Health System. She utilizes her 30 years of Healthcare IT experience to focus on digital transformation and establish enterprise programs such as Clinical Technology/ Biomedical Engineering and Cybersecurity at Alameda Health System.

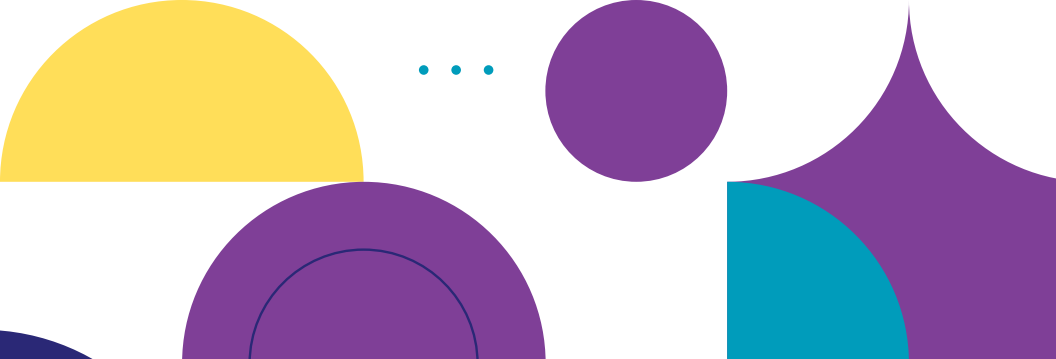
Achieve Financial Efficiency by Removing Enterprise Technology Debt

Health systems across the nation have been facing a financial crisis and are reactive to aging biomed equipment and the cybersecurity issues that they present. End of Life and End of Support equipment remain in the patient care environment to decrease capital expenditure, and yet organizations spend millions of dollars on rentals and countless resource hours to manage rentals and repairs. Alameda Health System (AHS) needed a creative way to upgrade the biomed equipment while still fulfilling its financial responsibilities.

Christine Yang established a set of criteria to standardize equipment and prioritize investment for the Biomed Refresh Program. In addition, she introduced a Refurbish Program for bed frames and gurneys which enabled AHS to save \$4+ million in new bed purchases while continuing to provide items comparable to brand new bed frames and gurneys under full OEM warranty for five years. Both the refurbish and refresh programs significantly reduced the repairment volume (400 open repairs to 100 open repairs) in just one year. A clinician survey also revealed dramatic improvement in satisfaction and confidence in the biomed program. Another positive financial outcome was the biomed rental cost savings. The projected rental savings with the new refresh and refurbish programs is over \$1 million annually.

“When you see something that is not right, not fair, not just, you have to speak up. You have to say something; you have to do something.”

John Lewis



**Changing healthcare.
Strengthening communities.
Empowering women.**



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