CAHL NOW

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for leaders who care®

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Dear CAHL Members:

We apologize for the lateness of the CAHL Winter 2020 newsletter. Despite our best intentions, we faced a number of challenges and setbacks with our publication schedule.

We think this issue is worth the wait and look forward to publishing the Spring 2021 issue very soon. Thanks for your patience!

- The CAHL Newsletter Editorial Team

CAHL NOW

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A MESSAGE FROM OUR CHAPTER REGENT

ACHE Regent's Role
Regents are the elected representatives of ACHE members residing in a set geographic territory and are the primary liaison between ACHE, state and local ACHE Chapters, and healthcare associations in their jurisdiction. Regents are also the primary conduit for communications between ACHE higher education network student chapters (HENs) and ACHE. As the elected representatives of ACHE members, Regents serve as advisors within the ACHE governance structure to the Board of Governors.

Thank you for this opportunity to share this message as part of the California Association of Healthcare Leaders (CAHL) Winter 2020 newsletter. As we start another new year, welcome to all of our newest CAHL and ACHE members, hello again to our continuing members, and congratulations to those who have recently advanced to, and recertified, their Fellow status.

As we begin a new year, now is a great time to reflect and give thanks for the incredible leadership the members of CAHL and ACHE have modeled in 2020. It was a year that was emotionally, mentally, spiritually, and physically draining – but it has also galvanized a strength and fortitude that brought out the best from our peers. While more than 500,000 Americans are no longer with us after succumbing to COVID-19, there are also thousands of lives that still continue to live and heal due to the work all of you have actively been engaged in during the past year. The stress and fatigue have been borne by you all with an unflinching devotion to continue to serve your communities, as you guide them in 2021, a year with promise as vaccines begin to be administered across the world.

We have come a long way in the past year across California:

- Jan 5: A man in Orange County tests positive for COVID-19, the first case in California, bringing the number of US cases to three.
- Jan 30: The World Health Organization declares the COVID-19 outbreak a global public health emergency. Nearly 8,000 people have been infected, mostly in China, and 170 have died.
- Feb 3: Santa Clara County declares a local health emergency due to COVID-19, the first county in California to do so.
- Feb 16: Some American passengers and crew members from the Diamond Princess, a cruise ship quarantined in Japan, are flown to Travis Air Force Base in Fairfield, where they will be quarantined for 14 days.
- Feb 26: A woman tests positive for COVID-19 in Solano County; it becomes the first case of community transmission in the U.S.
- And let's not forget the countless developments since then to now as vaccines are administered.

I am inspired by your fortitude, resilience, and indestructible spirit. You all still stand tall, with the compassion, humor, humility, devotion, and leadership that is part of your DNA. You continue to model these traits, and more, ensuring that members of your community will still thrive in to 2021 and not succumb to the pandemic. On this theme of leadership, our CAHL chapter and members have been leading by example, from where they are, via their pandemic response by continuing to mentor, network, educate, and learn from each other. A key benefit to being a CAHL and ACHE member is the ability to expand ones network and knowledge base to other individuals, organizations, and sectors of healthcare. Through this year's Virtual 2020 CAHL Congress chapter activities, we were able to reach out to peers and solicit advice and counsel related to various topics we are engaged with, particularly as they relate to researching evidence-based strategies or current best practices. The ability to tap into the resources of our peers has not only improved understanding of how different organizations have tackled the challenging landscape of healthcare in 2020 but also has resulted in collegial friendships and relationships that will only grow as we all dive-in to 2021.

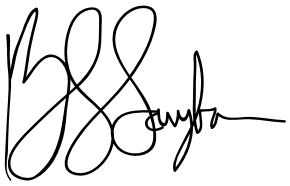
Thank you for the opportunity to offer this note on leadership to you this quarter. Whether related to leadership or any other topic, I would love to hear from you, so I can better serve as an advocate for the membership and CAHL Chapter. Please do not hesitate to reach out to me at bsangha@alamedahealthsystem.org with thoughts, suggestions, challenges, and insights.

Finally, please do not hesitate to access the events, tools and resources from ACHE, including:

- **ACHE Self Study Courses:** ACHE's self-study courses are now available in an all-new digital format, accessible from your desktop, laptop or mobile device. Courses are accessible in a self-directed format and build on the expertise found in books published by Health Administration Press. Upon completion of the course, participants earn six ACHE Qualified Education credit hours that can be applied toward advancement to Fellow or recertification. To learn more about the digital self-study courses, visit www.ache.org/selfstudy.
- **ACHE Tuition Waiver:** ACHE recognizes many are experiencing economic hardships during this time. We have a limited number of tuition waivers available for our Members and Fellows. You must have been a member for at least one year and not have received a tuition waiver within the last three years. Application deadline is Jan. 25. Submit your tuition waiver application today.
- **Register for CAHL Congress 2021:** We invite you to register for the 2021 Congress on Healthcare Leadership, March 22–25. Join us for this reimagined virtual experience and earn up to 12 ACHE Face-to-Face Education credits. Our Congress agenda features keynote speakers including:
  - Anthony S. Fauci, MD, director, National Institute of Allergy and Infectious Diseases
  - Atul Gawande, MD, surgeon, Brigham and Young Women's Hospital/writer, The New Yorker
  - Keller Rinaudo, co-founder/CEO, Zipline
  - Amy Walter, national editor, Cook Political Report/host, "The Takeaway."
  - Wes Moore, CEO, Robin Wood
  - Indu Subaiya, MD, co-founder/president, Catalyst @ Health 2.0

Check back often. Sessions and speakers are being added to our Congress lineup every week. The registration process has changed. Please register today for your Congress all-access pass. After registering for the Congress event, you will receive a communication in March to select your sessions and personalize your schedule in the virtual event platform.

With Gratitude,



Baljeet S. Sangha, MPH, FACHE
Vice President, Support Services
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A MESSAGE FROM OUR CHAPTER PRESIDENT

Leading with Heart

There is a need now more than ever to practice empathy and kindness in all aspects of life. This is especially true for leaders. As the pandemic, social and civic unrest, and financial crisis continue to impact healthcare, moral injury, distress, and residue are being experienced at alarming rates. This requires heightened awareness and immediate action. But how do you do it for others, when you yourself are experiencing the same thing?

Why are moral injury, residue, and distress occurring? Let's first take a look at moral injury. There is no predictable set of causes, but there are experiences that create a risk for moral injury. They involve high-stakes situations, such as life and death, a high risk for failure, no clear right and wrong choices, and harm done.[1] A person can have moral injury not only from directly inflicting harm but also from witnessing it happening, hearing about it, or surviving be-ing harmed. Moral injury from being harmed involves trusting people with power who fail to do the right thing. Experiencing harm may involve feeling betrayed, humiliated, frustrated, furious, and ashamed of being contaminated by the negativity. People may also do things to survive that violate their conscience, and they therefore believe they are no longer good.

Healthcare frontline staff are experiencing moral injury as a result of: the lack of PPE, well fitting and clean PPE, accurate and timely information, staff, mental health support and access, and administrative support within organizations and at the state and federal levels. It is also a result of the experience of being "disposable" or "expendable"

"Actively listen, acknowledge feelings being expressed and situations as they are being seen, recognize the best someone has to give may be less than what they are capable of and have exemplified in the past..."

– seeing athletes, movie stars, and politicians receive testing and therapies not available to those risking life daily. We have observed the dichotomy of federal regulators being inconsistent with the approach to addressing COVID, initially downplaying the severity and then going against science and data in taking steps to eradicate the spread. We have seen our frontline heroes provide physical, emotional, and compassionate care without receiving it themselves from those in positions of power. All of these factors contribute to moral injury.

Next let's take a look at moral distress. Moral distress is the emotional state that arises from a situation when a front line staff member feels that the ethically correct action to take is different from what he or she is tasked with doing.[2] When policies or procedures prevent a front-line staff member from doing what he/she thinks is right, that presents a moral dilemma. Picture a patient in the last hours of his/her life who is unable to have visitors. The nurse caring for the patient has multiple patients, each more acutely ill than the other. Moral distress arises when, as a result of a no visiting policy in response to COVID-19 mitigation, the nurse must leave the patient's bedside to care for another patient, risking the first patient dying alone.

Moral residue is long lasting and powerfully integrated into one's thoughts and views of the self. It is this aspect of moral distress—the residue that remains—that can be damaging to the self and one's career, particularly when morally distressing episodes repeat over time. It is characterized by three components: emotional exhaustion, depersonalization, and personal accomplishment. Moral distress is the inability of a moral agent to act according to his/her core values and perceived obligations due to internal and external constraints.[3] Moral injury, distress, and residue are the tenets of burnout. So what's a leader to do?

Actively listen. Acknowledge feelings being expressed and situations as they are being seen. Recognize the best someone has to give may be less than what they are capable of and have exemplified in the past. Engage in dialogue mirroring concerns and collaborating to find an in-the-minute solution. Act with empathy, grace, and kindness not only for others, but for yourself as well. Be a hero for the heroes on the front line. It can be as simple as four words: How can I help? And then listen to the answer. Success as a leader is not having all the answers, not putting up a shield to appear strong, not dictating the direction. It is asking for opinions to gather answers, being vulnerable and acknowledging your own concerns and doubts, and recognizing that the key to success is taking it day-by-day, sometimes minute-by-minute. Making a decision with an open heart usually results in the right decision.[4]

Be Safe. Be Well.

Kim Brown-Sims, MBA, RN, FACHE
Chief Executive Officer, KBS Leadership Consulting
Chapter President

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LEADERSHIP AND CAMARADERIE

By Capt Sara Salmeri

As I prepared myself for Basic Military Training, the most common advice I received from my military friends was to not volunteer for anything and to blend in as much as possible. I tried my best to follow this advice, but on my second day of training, I was selected as an Element Leader. I knew that my newly appointed position meant I would be at the front of our formation and being at the front meant I would get noticed if I made a mistake. Therefore, the thought of being a "leader" was terrifying. The Drill Instructor explained that it was the Element Leader's job to prepare the flight for the graduation parade and to complete flight tasks correctly and timely. There were 19 other females in my element from different backgrounds, life experience and even different cultures. This was my first experience being responsible for peers and the thought of making sure our Recruit Team didn't screw-up and were successful in their responsible tasks, duties and assignments made me nervous and, yes, a bit anxious.

Once our performance (or lack thereof) started to have consequences, I began to feel the pressure. I recall during an inspection, one of my members failed because her ponytail was below her collar. The Drill Instructor called me to his location and asked me "Why is your Element the only one who can't follow standards? Is this acceptable to you?" Understanding this was a rhetorical question, I said "No Sir!" The Drill instructor ordered me to do push-ups until I was told to stop. My first thought was "This is not fair! Why am I being punished for someone else's actions?" This feeling brought me back

"I had the epiphany that if I wanted to succeed at leading my Team, I had to get to know them so that I could take care of them as if they were my sisters."

to childhood when I got in trouble for things my siblings did or failed to do. As I did push-ups, I had the epiphany that if I wanted to succeed at leading my Team, I had to get to know them so that I could take care of them as if they were my sisters. That night, I got my Team together and we all discussed the reasons we decided to serve in the Air Force and shared a few facts about our personal life. As the training progressed, we became closer and started to trust and care for one another. We all had a common goal to complete the training and march in the graduation parade together. While there were many challenges in between, we all successfully completed the eight-week military training program and gained a higher sense of purpose and confidence along the way.

This experience had a huge impact on my leadership perspective and outlook. As my military career resulted in promotions to higher ranks and generated more responsibility within the Air Force, I have never forgotten to show my subordinates genuine interest in their well-being. This helps me build trust and keeps me grounded in my leadership purpose. While I realize my training experience is unique to the military, this lesson can be applied to the private sector as well. When team members see one another as respected colleagueswho have each other's back, there is no limit to what can be accomplished. This may seem simple in theory but difficult in practice. So what is the first step? Invest time in getting to know your individual team members. This can be done through something as simple as a questionnaire or a one-on-one session with each individual, so you can get answers to questions such as: Why did they decide to join your company? What are their goals? What motivates them? What do they value? Do they have any challenges that can affect their work? If so, how can you as the leader help them achieve their goals and overcome any obstacles or barriers? This will improve team communication and provide a healthy team focus to get the mission done!

CAHL CONGRESS VIRTUAL SERIES:

LOOKING BEYOND THE PROJECT SCHEDULE, BUDGET, AND SCOPE

By Sarah T. Khan, Navpreet Atwal, Sachin Gangupantula

The year 2020 offered more uncertainty and change than ever before. This was true in every industry globally, as well as for CAHL. Pivoting CAHL Congress from a two-day, in-person conference to a virtual series became the year's silver lining (refer to figure 1). The series represented an opportunity for the chapter and its volunteers to continue to advance mission-orientated work, redefine success, foster new relationships, embrace greater risks and learn from failures. Despite the difficulties, the experiences and learnings highlight the need to evaluate success using quantitative and qualitative measures comprehensively. Below we discuss some qualitative measures of CAHL Congress' success that have placed CAHL on a brighter future trajectory.

Advancing the Mission

Due to the 2020 economic downturn and related job loss, CAHL's Board made the decision to offer the CAHL Congress series at minimal or no costs to the chapter members and the broader healthcare community. This decision helped to continue advancing CAHL's mission of maximizing networking opportunities, receiving education, and pursuing career advancement.

Redefining Measures of Success

Adherence to the project schedule is one of the measures of successful project performance. However, in a case such as CAHL Congress, when the original schedule becomes unachievable, it is even more critical to realign the project schedule and activities in order to provide structure to the team members executing the work. To promote efficiency and ensure project success, previous processes, such as the number of communication channels, governance structure and other in-use techniques and tools, must also be reassessed.

Fostering New Relationships

Leveraging technology to deliver CAHL Congress content virtually helped to remove previous barriers such as geographical limitations. Although not an explicit agreement across all ACHE chapters, cross-chapter event participation was commonplace even when participant capacity was limited. Encouragingly, this led to CAHL members learning from leaders across the country and opened the door for future collaborations across ACHE chapters.

Embracing Risk and Failure

The initial plan to host CAHL Congress in-person presented a risk to the chapter as a first-time venture. The unexpected transition to a virtual series was equally risk-evoking, especially with the online education programming spaced over several months. However, chapter leaders and the project team members embraced a "fail early to improve" mindset, which led to continuous improvement in event production quality and communications. The lessons learned from each session added to the chapter's existing and collective knowledge bank, which will be leveraged for 2021 programming.

Closing

At the closure of a project, activities such as post mortem reports and lesson learned documentation are used to measure the success of a project via quantitative metrics such as variance analysis of scope, budget, and timeline. Reflecting on the invaluable experiences gained during 2020, we need to think more comprehensively about measuring success via qualitative means within CAHL, ACHE, and our professional work lives.

11 Total sessions from July - November 2020, after formalizing the pivot to virtual education in June

Produced 4 Qualified Education events (6 credits total) & 6 total F2F sessions (9 credits total)

MEMBER EDUCATION

MEMBER SATISFACTION

Average audience satisfaction score of 4.7/5 on Face-to-Face and Qualified Education events

Exceeded 600 attendee throughout the series

CONGRESS PERFORMANCE

COST OF ATTENDENCE

All sessions made available to members free of cost and discounted rate by those impacted by COVID-19

LEADING WITH AN ETHOS OF LIGHT

By Priscilla Knolle

A leader has the power to project either shadows or light onto the lives of the people he or she is around.[1] There is a necessary journey one must undertake to intentionally lead with an ethos of light.

During the 1994 Rwandan Genocide against the Tutsi, a million people were killed, and an estimated 500,000 women and girls raped in 100 days.[2] Jacqueline Bagwiza, orphaned during the 1994 genocide, lived at the Agahozo Shalom Youth Village (ASYV) in Rwanda, from 2008 to 2013, later moving to Canada for further education as a MasterCard Foundation scholar. The ASYV community, formed by American, Anne Heymann, consisted of several family clusters of a mother and siblings. The foundational belief of the community is that transformational healing can occur as long as the distressed children are given the opportunity to have hope for the future. Jacqueline writes how she spent her years prior to ASYV in "deep insecurity." But here, Jacqueline was provided a loving environment of great grace, where she learned the Jewish principles of *Tikkun Halev*—repairing the heart—and *Tikkun Olam*—repairing the world. These principles of hope and dream-making became central to her daily living.[2]

Jacqueline remembers Anne reflecting on thoughts that life was made of a past, present, and a future, and when this line is broken in the past, there is a need for someone to step in and mend the present so that a new future can re-merge from solid ground. "We were all orphans," writes Jacqueline, but their courage came from the "mothers" who helped them transform grief into courage—by transmuting suffering and mourning without shame. Anne's mother, Mama Any told her that she had a beloved one inside of her and that she was beautiful when she smiled— a concept so new to her that this incident set her on a new self-discovery. Such practices are also practices of care. Practices of care are actions that seek to preserve ways of know-

"The foundational belief of the community is that transformational healing can occur as long as the distressed children are given the opportunity to have hope for the future."

ing and being, not by backward traditionalism but by creative expressions of adaptive leadership.[2] Jacqueline and the other orphans strive to complete the unfinished work of their beloved ones, whom they hold close in their hearts and honor through practices.[2]

Bagwiza utilized Tikkun Halev to lift her dormant creativity through art (through her paintings, Bagwiza raised $300,000) and embodied Tikkun Olam by helping the creation of a just world through engaging in acts of kindness for others, such as repairing destroyed homes and helping at the health center. After I read Jacqueline's essay, I was fortunate to connect with her, and she said, "*Tikkun Halev* and *Tikkun Olam* have done me good, and continue to do so. I am very thankful!" Currently, she continues to focus on youth and educational leadership.

Key themes of leadership from Jacqueline's story are reflected as "seeds," or core values, "plants," or wise actions, continual reflection, and ability to interrogate one's assumptions, engaging appropriately with power, and practices of care and inclusivity.[2]

Good leadership comes from people who have penetrated their own inner darkness to travel out into the light and are then capable of leading others to a place of wholeness because they have been there and know the way.1 Mama Any taught Jacqueline that holding onto sorrow would nurture darkness in one's heart, and it was important to transmute the sorrow, and transform that into light and life.[2]

With the relentless assault of the COVID-19 pandemic throughout our country and worldwide, we have been distressed as a healthcare community. We lost a sense of continuity and instead were dislocated. It is only when we, as healthcare leaders, find ourselves responsible for the future, can we have hope in order to offer hope.[3] It is through this time of going inward and deeper to first understand these shadows, can we, as leaders, journey from the shadows into the light, and provide an ethos of light for others.

The great illusion of leadership is to think that a person can be led out of the desert by someone who has never been there."[3] We have been there. We are there—in the brokenness, the darkness, and the loss—and as Jacqueline learned successfully, we can be assured that leadership is on the other side of this transmutation of suffering. When someone's past has become broken from the hurts of a difficult environment, are we ready, as leaders, to step in and mend the present to make way for a stronger future, for individuals, organizations, and the community? Are we able to see the light and, as leaders, to share it with others?

Author Bio

Priscilla Knolle is a Clinical Transformation Physician consultant with core belief in organizational health and our human journey toward stability and sustainability. She serves on the CAHL Clinical Leadership Committee and the CDTC Mentor Sub-Committee.

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EFFECTIVE LEADERSHIP AND MANAGEMENT IN HEALTHCARE: KNOWING WHEN TO PIVOT

By Andrew S. James, RN, MS, MHA

If leadership and management were easy, everyone would succeed in managing healthcare entities, and outcomes would, at all times, be flawless. Healthcare is one of the most complex non-linear systems. This is because of its many moving parts, which consist of people, processes, subprocesses, macrocultures, microcultures, and regulations – not to mention internal and external administrative and political pressures. [1] In addition, there is no way of properly preparing in advance for certain unique events that may occur, such as the COVID-19 outbreak. The national state of emergency that this engendered worldwide has led to societal lockdowns and unreliable supply chains for personal protective equipment (PPE) and medical devices. Those engaged in healthcare operate in various environments that can range from simple to chaotic; this can plunge operations into total disorder if the right type of leadership style and management tactics are not employed.

Healthcare leaders often use a single "one-size-fits-all" approach to problem-solving and tend to favor the leadership and management methodologies to which they are most habituated; however, this style may not work well in all environments and could potentially lead to catastrophic failure.[2] For example, a collaborative and participative leadership style, or the use of LEAN process improvement methodology, will likely prove ineffective during times of crisis, where the environment is chaotic and operations have stalled because of factors unknown. The key to successful leadership and management is to become situationally aware, to know when to pivot, and to use the right type of leadership style and management tactics to effectively respond and manage the situation.
The Cynefin (pronounced 'kuh-NEV-in') Leadership Sense Making Framework is a highly effective decision-making tool, which helps leaders contextualize and understand the environment, allowing them to then respond appropriately.

The Cynefin Framework is founded on the study of complex adaptive systems (CAS), as well as accompanying research in the field. It was developed in 1999 by David Snowden, a Welsh management consultant and researcher in the field of knowledge management and complexity science. 3 The Welsh word cynefin has no direct English translation. It is usually approximated to "habitat," but a better notion might be "the place to which one is acclimatized, where one lives, or one is born." In any case, it alludes to the myriad affiliations each of us has with people, processes, and cultures; we are never fully aware of these affiliations, but the patterns of experience that emerge from them do indeed influence our interactions. The idea is that "habitat" provides a notional locale from which those

responsible for making decisions can view their choices. The Cynefin Framework has been applied in many different industries; by applying it to the healthcare industry we can gain valuable insights into our practice, our organizations, and our profession.1,3 Although the Cynefin Framework was designed to assist with corporate knowledge, strategy management, and decision-making, it can be used by leaders at all levels, down to the department and project level. [2]

"Healthcare leaders often use a single "one-size-fits-all" approach to problem-solving and tend to favor the leadership and management methodologies to which they are most habituated; however, this style may not work well in all environments and could potentially lead to catastrophic failure"

The Cynefin Framework breaks the environment into four types of domains; these are classified as simple, complicated, complex, and chaotic. Simple and complicated domains are known as ordered domains because the causes and effects of issues within these are known. Complex and chaotic domains are not ordered domains because the causes and effects of issues arising are not known. [2,3]

SIMPLE DOMAIN

This is an ordered domain, where the relationships of cause and effect are readily understood. The process is stable, easy to comprehend, and predictable. If a problem occurs, the fitting solution is one that is established and obvious; the majority of employees with a modicum of experience will be able to resolve it. Individuals within this domain will likely have a shared understanding of how things work; there is little chance of dispute, and decisions are not questioned but rather understood and followed. [2] The simple domain is rarely subject to change and is indicative of a turnkey operation. Management within this domain is straightforward, and work is coordinated without the necessity for extensive communication between employees and managers. Under this domain, leaders must ***sense › categorize › respond***. [1] A pertinent example might be a patient check-in through discharge process at an ambulatory primary care clinic or a dialysis center.[2] Nevertheless, within the simple domain, problems do arise from time to time. These may result from complacency or inflexible thinking of employees; these issues are, however, quickly resolved by the adoption of new best practices or the creation of new guidelines.[2,3]

COMPLICATED DOMAIN

This is also an ordered domain. Although its interactions and patterns are complicated, the cause and effect relationships are clear; there may be multiple right answers to questions that arise, though not all individuals involved will comprehend this. This environment has 'known unknowns'. Leaders must ***sense › analyze › respond***. This approach is not easy, often requiring business, clinical, regulatory,

legal, or other subject matter expertise. Good practices might be better than best practices.[2] For example, wearing a surgical mask with a face shield (good practice) might be a better option than wearing an N95 mask (best practice) in the emergency department because there might be a greater need for N95 masks in the ICU or COVID-19+ units – and employees can wear the surgical mask with a shield for an entire shift without discomfort. Experts from CDC and state and county public health departments may, however, offer differing answers and recommendations. Jumping on the proverbial bandwagon may occur and can prove to be dangerous when experts begin to agree with each other and package a solution that may not be the right solution. "Analysis paralysis" describes another situation in which experts may continue to strive, ultimately fruitlessly, to arrive at a putative perfect solution. Leaders here must be cognizant and wary of this phenomenon.3 The leadership style demanded in this context is primarily collaborative and participative but not limited to the involvement of, and collaboration with, experts. Ideas from all individuals must be welcomed and encouraged, including ideas from those who may are not established subject matter experts. Decisions must be made by the leader after careful analysis and the consideration of all ideas and recommendations, including controversial ideas that may go against the advice and opinions of established experts. [1,2] Scenario planning, Six Sigma statistical analysis, and simulations are all highly effective in this environment.

COMPLEX DOMAIN

This is not an ordered domain; under the complex domain at least one right answer exists, but it is far from easy to discover it. This is an environment of "unknown unknowns."[2] To illustrate this, note the differences between two complex systems. A US Airforce F35 fighter jet, for example, is a complex machine; however, it is one that has a degree of consistency in terms of its constituent parts. A team of expert mechanics and engineers would be able to dismantle it and actively reassemble it in a matter of hours or days. Contrast this with the healthcare system – also a highly complex entity but one that is always in a state of flux. The whole is far more than the sum of its parts, and it can be highly unpredictable. In this domain things

The Cynefin Framework

SIMPLE DOMAIN
sense → categorize → respond

COMPLICATED DOMAIN
sense → analyze → respond

COMPLEX DOMAIN
probe → sense → respond

CHAOTIC DOMAIN
act → sense → respond

can only be understood in retrospect, through careful observation and the interpretation of patterns as they emerge. Any solution to a problem would have to be discovered. Leaders must conduct short, rapid, one-to-two-week experimental cycles to determine if a solution could work or fail. Leaders must ***probe › sense › respond***.

"The infection rate surged so rapidly that hospitals ran out of ER and ICU beds, PPE provision was subject to severe shortages, and supply chains were disrupted; in short, the entire healthcare system veered close to collapse..."

Adaptive, collaborative, and participative leadership is required. More importantly, leaders must remain optimistic and open-minded, continuing to foster creativity and innovation within their teams to find the right solution and develop new practices to resolve issues.[2,3]

CHAOTIC DOMAIN

This is not at ordered domain. Under the chaotic domain, searching for the right answers is futile. It is impossible to be certain about the relationships between cause and effect; understanding them is simply not a possibility because there are multiple problems that keep shifting. It is difficult to keep track of error patterns and to determine what is happening because of the tumultuous environment. This is a domain of true unknowables.[2,3] The crisis engendered by the COVID-19 pandemic is a perfect example here. The infection rate surged so rapidly that hospitals ran out of ER and ICU beds, PPE provision was subject to severe shortages, and supply chains were disrupted; in short, the entire healthcare system veered close to collapse not only in several parts of the United States but also in many other parts of the world. In this domain, operations are severely impacted to the point of coming to a complete halt. In a chaotic situation, a leader does not have time to watch for patterns, to extrapolate sense from these, and then respond. The mindset of leaders must focus on the quick prioritization of issues and problems and then immediate resolution.[1] Leaders need to make decisions quickly and act quickly and implement novel practices to deal with issues. The emphasis needs to be on bringing order and stability to the environment. Within this domain, leaders must ***act › sense › respond***. A command-and-control leadership style must be employed, doing what is

necessary to keep operations moving; this would include the removal of individuals from areas of responsibility should they become indecisive and fail to act or comply. Communication needs to be direct, top-down, and imperative. [2]

Leaders need to act in order to shift the chaos environment to a complex environment, where emerging patterns can be studied and experimentation applied to solve new problems.[2] In the aforementioned example of the COVID-19 crisis, hospital leaders were required to act quickly, stabilize the environment, and prevent fear spreading amongst healthcare staff and within the community. The ER, ICU, and other areas of the hospitals had to remain open; space issues had to be quickly resolved. New COVID-19 management units had to be opened and staffed adequately. Resources such as PPE, ventilators, rotation beds for proning patients, ECMO devices, and novel therapeutics needed to be procured and deployed effectively. There was no time to consider where COVID-19 clusters were emerging and why. The focus shifted toward what to do in order to keep treating patients effectively, saving as many lives as possible, and preventing the collapse of the healthcare system.

Many leaders lead effectively in one or two types of environments, most likely the simple and complicated ordered domains. Leaders whose education and organizational experience of ordered domains equips them to deal with these "habitats" are often simply not equipped to steer their organizations through domains and contexts that are not ordered. This could create limitations that might ultimately lead to catastrophe if leaders erroneously identify domains that are not ordered as ones that are and take decisive action under this misapprehension.2 Leaders at all levels of healthcare must know when to pivot in order to successfully lead. The Cynefin Sense Making Leadership Framework provides an understanding of ordered domains and ones that are not ordered. The Cynefin Framework additionally provides direction as to what leadership style and management methodology to use in each type of domain, as well as how to focus to resolve problems and issues effectively. Leaders must have a fluid mindset and must quickly to various situations, taking decisive action to manage the environment. Having knowledge of various domains, as outlined in the Cynefin Framework, gives leaders an advantage, preparing them to move swiftly from one domain to the next, successfully resolving issues. The key advantage of using the Cynefin Framework is taking decisive actions at the right time.

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VOLUNTEER SPOTLIGHT

FAYOLA EDWARDS-OJEBA, MD

- Founder & CEO, RechargedMD
- Clinical Leadership Committee

Fayola Edwards-Ojeba, MD, is the founder and CEO of RechargedMD. As a board- certified internist and former Clinical Assistant Professor at UCSF, Dr. Edwards-Ojeba has cared for patients and taught internal medicine residents. She graduated from Harvard College with honors, attended Yale Medical School, and completed her Internal Medicine Residency training at UCSF. Dr. Edwards-Ojeba is currently an attending physician at UCSF, a member of the American College of Healthcare Executives, the American Medical Women's Association, and serves on the Board of the California Association of Healthcare Leaders. During her time as a practicing physician, she has experienced the deep gratification and frustration of clinical practice. She overcame the struggles of burnout with the tools and services she turned into RechargedMD.

She aims to change the national discourse around burnout to focus on systems-level challenges and solutions in our current healthcare landscape. Through RechargedMD, her mission is to positively impact the healthcare system and improve the practice of medicine for clinicians and patients alike.

How has volunteering with CAHL contributed to your personal/professional life in a meaningful way?
From my very first networking event with CAHL, I felt welcomed and accepted by their organization. During this event, a number of members introduced themselves, and I was able to make connections right away. It made me feel that I was in a supportive environment and a valuable member of the group. Not only have they been inviting, but a helpful and collaborative resource to bring member ideas to life. CAHL continues to be a source of industry knowledge and has shared their platform to raise awareness of the critical issue of physician burnout.

Why do you continue to volunteer with CAHL?
It has been exciting to see the way that CAHL continues to grow its member base and industry initiatives. Their Justice, Equity, Diversity, and Inclusion initiatives (JEDI) are what really stands out to me. Being a woman of color in medicine, it's reassuring to know the organization prioritizes these important matters. I'm appreciative to be on a board where these issues are at the forefront of their mission and vision. With this in mind, I look forward to volunteering and moving the needle with their organization.

Why did you choose a career in healthcare administration?
As a general internist, I have had the honor to train at several top institutions, alongside some of the best physicians. This training taught me the skills to provide quality patient care. However, I also discovered a negative side to medicine – moral injury. It was through my own self-discovery and experience of physician burnout that I realized how widespread the issue really was. After speaking with several colleagues, it was apparent that physicians needed better resources and systems-based solutions to physician burnout. This is what led me to starting RechargedMD. Through my work with RechargedMD, I hope to transform healthcare and bridge the gap between healthcare administrators and physicians. All in all, we want to create a better experience for physicians and patients alike.

A motto or quote that influences your leadership style.
A motto that I live by is to simply, "be kind". Being in medicine, you see a lot of illness, grief, and strife. If you can be that one kind person and leave someone feeling cared for- it can make all the difference, especially during this challenging time. This same standard is what governs my relationships with my fellow colleagues and those I lead within RechargedMD. As physicians and community members, I encourage you to make a positive impact on someone's life.

VOLUNTEER SPOTLIGHT

AEMAL AMINY

- Director, Security, Parking & Transportation; Alameda Health System
- Diversity and Inclusion Committee (D&I)

Aemal has truly demonstrated his commitment to diversity and inclusion and volunteerism based on his actions. He engages everyone on the team, elicits feedback, and bridges gaps between and among various stakeholders. He also demonstrates commitment through the partnerships he creates within CAHL, beyond the D&I Committee, by always stepping up to support identified needs. Aemal has really taken a leadership role in the D&I Committee. He has spearheaded the development of both our D&I questions for CAHLCon as well as our D&I checklist for panelists and moderators. He takes absolute ownership of D&I and is always one of the first to engage and lead.

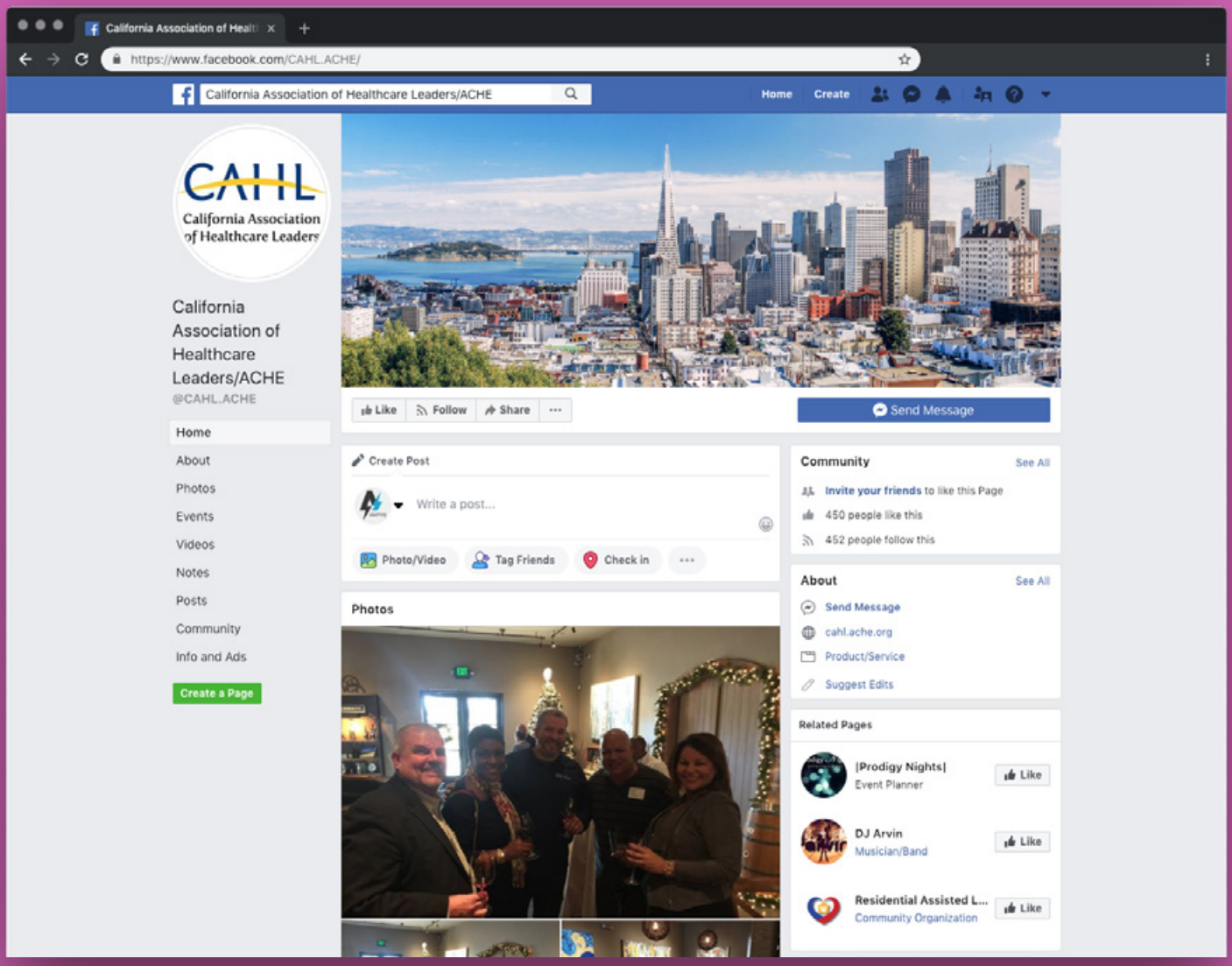
How has volunteering with CAHL contributed to your personal/professional life in a meaningful way?
Volunteering with the California Association of Healthcare Leaders (CAHL) has contributed to my life profoundly. On a professional level, volunteering with CAHL has afforded me the opportunity to work alongside influential healthcare leaders who share the same vision and desire to advance justice, equity, diversity, and inclusion in healthcare, concomitantly contributing to the advancements of healthcare's iron triangle for our communities. On a personal level, volunteering with CAHL provides me an intrinsic feeling that continuously inspires me to put in the work necessary to make healthcare accessible, safe, and inclusive for everyone.

Why do you continue to volunteer with CAHL?
I continue volunteering with CAHL because of my passion for healthcare. I believe that now, more than ever, is a vital time to ensure an emphasis is placed on addressing healthcare's deficiencies. By working side by side with impactful leaders and actively participating in important discussions that shape the community's health and our workplace environment – we are truly enhancing the lives of those we work with daily and have committed to serving in our profession. Volunteering with CAHL makes this possible.

Why did you choose a career in healthcare administration?
Healthcare administration wasn't my first career choice. I had a successful career in finance but transitioned to healthcare because I wanted to give back to the world and the community. At the end of each workday, I wanted to feel like I had contributed to the world, that I made a positive impact on people's lives at a macro level. Any profession will provide you a paycheck and sustenance; however, there aren't many professions that make you feel wonderful about your daily contributions. Healthcare administration provides me the reassurance that I am helping people through my profession.

A motto or quote that influences your leadership style
"We need leaders who add value to the people and the organization they lead; who work for the benefit of others and not just for their own personal gain. Leaders who inspire and motivate, not intimidate and manipulate; who live with people to know their problems in order to solve them and who follow a moral compass that points in the right directions regardless of the trend.

Like our page



NATIONAL NEWS | Q4

SAVE THE DATE: VIRTUAL CONGRESS

We're excited to announce our first-ever virtual Congress on Healthcare Leadership, March 21–25, 2021, and invite you to save the date as we count down to a stellar education and networking opportunity.

FACHE® MEMBERSHIP TENURE REQUIREMENT CHANGE

As a reminder, the Board of Governors made the decision to change the membership tenure requirement for initial Fellow advancement from three years to one year effective Jan. 1, 2021. We remain confident the change will make Fellow status possible for more of our Members who meet the requirements and wish to advance to this important leadership level.

Keep in mind that while the membership tenure requirement was adjusted, the other requirements for Members to obtain the FACHE credential remain the same.

If you have any questions about the FACHE requirements, the deadline extensions or the process in general, please reach out to our Customer Service Center at contact@ache.org or (312) 424-9400, Monday through Friday, 8 a.m. to 5 p.m., Central time.

COMPLIMENTARY CAREER RESOURCE CENTER WEBINAR SERIES

The career landscape continues to evolve, creating new expectations and requiring enhanced expertise while navigating the potential opportunities ahead. ACHE's Career Resource Center hosted a webinar series designed to support members covering such topics as "The NEW Networking Model", "Building Confidence and Defining Your Executive Presence", and exploring "The Role of an Executive Coach" in your ongoing career and leadership development pursuits. To view these webinars, please visit https://www.ache.org/career-resource-center/career-resource-webinars

ACHE NOMINATING COMMITTEE SLATE

The ACHE Nominating Committee has agreed on a slate to be presented to the Council of Regents at the Council of Regents meeting in March. All nominees

have been notified and have agreed to serve if elected. All terms begin at the close of the Council meeting. The 2021 slate is as follows:

Nominating Committee Member, District 2 (two-year term ending in 2023)
Jhaymee Tynan, FACHE
Assistant Vice President, Integration
Atrium Health
Charlotte, N.C.

Nominating Committee Member, District 3 (two-year term ending in 2023)
John M. Snyder, FACHE
President
Sanford Health Plan
Sioux Falls, S.D.

Nominating Committee Member, District 6 (two-year term ending in 2023)
Lt Col Stephanie S. Ku, FACHE
U.S. Air Force

Governor (three-year term ending in 2024)
Carolyn P. Caldwell, FACHE
CEO
Dignity Health-St. Mary Medical Center
Long Beach, Calif.

Governor (three-year term ending in 2024)
Karen F. Clements, RN, FACHE
CNO
Dartmouth Hitchcock
Lebanon, N.H.

Governor (three-year term ending in 2024)
Michael O. Ugwueke, DHA, FACHE
President/CEO
Methodist Le Bonheur Healthcare
Memphis, Tenn.

Governor (three-year term ending in 2024)
COL Brett H. Venable, FACHE
U.S. Army

Chairman-Elect
Anthony A. Armada, FACHE
President/CEO
AHMC Seton Medical Center and AHMC Seton Medical Center Coastside
Daly City, Calif.

Additional nominations for members of the Nominating Committee may be made from the floor at the annual Council of Regents meeting.

Additional nominations for the offices of Chairman-Elect and Governor may be made in the following manner: Any Fellow may be nominated by written petition of at least 15 members of the Council of Regents. Petitions must be received in the ACHE headquarters office (American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698) at least 60 days prior to the annual meeting of the Council of Regents. Regents shall be notified in writing of nominations at least 30 days prior to the annual meeting of the Council of Regents.

NATIONAL NEWS | Q4

ACHE CALL FOR NOMINATIONS FOR THE 2022 SLATE

ACHE's 2021–2022 Nominating Committee is calling for applications for service beginning in 2022. ACHE Fellows are eligible for any of the Governor and Chairman-Elect vacancies and are eligible for the Nominating Committee vacancies within their districts. Those interested in pursuing applications should review the candidate guidelines for the competencies and qualifications required for these important roles. Open positions on the slate include:

- Nominating Committee Member, District 1 (two-year term ending in 2024)
- Nominating Committee Member, District 4 (two-year term ending in 2024)
- Nominating Committee Member, District 5 (two-year term ending in 2024)
- Four Governors (three-year terms ending in 2025)
- Chairman-Elect

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

- **District 1:** Canada, Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
- **District 4:** Alabama, Arkansas, Kansas, Louisiana, Mississippi, Missouri, New Mexico, Oklahoma, Tennessee, Texas
- **District 5:** Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming

Candidates for Chairman-Elect and Governor should submit an application to serve that includes a copy of their resume and up to 10 letters of support. For details, please review the Candidate Guidelines, including guidance from the Board of Governors to the Nominating Committee regarding the personal competencies of Chairman-Elect and Governor candidates and the composition of the Board of Governors.

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

Applications to serve and self-nominations must be submitted electronically to jnolan@ache.org and must be received by July 15. All correspondence should be addressed to Heather J. Rohan, FACHE, chairman, Nominating Committee, c/o Julie Nolan, American College of Healthcare Executives, 300 S. Riverside Plaza, Ste. 1900, Chicago, IL 60606-6698.

The first meeting of ACHE's 2021–2022 Nominating Committee will be held in spring 2021. Following the July 15 submission deadline, the committee will meet to determine which candidates for Chairman-Elect and Governor will be interviewed. All candidates will be notified in writing of the committee's decision by Sept. 30, and

candidates for Chairman-Elect and Governor will be interviewed in person on Oct. 28.

To review the Candidate Guidelines, visit ache.org/CandidateGuidelines. If you have any questions, please contact Julie Nolan at (312) 424-9367 or jnolan@ache.org.

SAFER TOGETHER: A NATIONAL ACTION PLAN TO ADVANCE PATIENT SAFETY

ACHE joined members of the National Steering Committee for Patient Safety to author Safer Together: A National Action Plan to Advance Patient Safety to provide health systems with renewed momentum and clearer direction for eliminating preventable medical harm.

Safer Together: A National Action Plan to Advance Patient Safety draws from evidence-based practices, widely known and effective interventions, exemplar case studies and newer innovations. The plan is the work of 27 influential federal agencies, safety organizations and experts, and patient and family advocates, first brought together in 2018 by the Institute for Healthcare Improvement.

The knowledge and recommendations in the National Action Plan center on four foundational areas deliberately chosen because of their widespread impact on safety across the continuum of care:

1. Culture, Leadership, and Governance: The imperative for leaders, governance bodies and policymakers to demonstrate and foster deeply held professional commitments to safety as a core value and promote the development of cultures of safety.
2. Patient and Family Engagement: The spread of authentic patient and family engagement; the practice of co-designing and co-producing care with patients, families and care partners to ensure their meaningful partnership in all aspects of care design, delivery and operations.
3. Workforce Safety: The commitment to the safety and fortification of the healthcare workforce as a necessary precondition to advancing patient safety; the need to work toward a unified, total system perspective and approach to eliminate harm to both patients and the workforce.
4. Learning System: The establishment of networked and continuous learning; forging learning systems within and across healthcare organizations at the local, regional and national levels to encourage widespread sharing, learning and improvement.

For ACHE resources on advancing patient safety, visit ache.org/Safety. There you will find Leading a Culture of Safety: A Blueprint for Success, which gives CEOs and senior leaders a tool to both assess and advance their organization's culture of safety.

ARTICLES OF INTEREST | Q4

HOPE IN ACTION

By nature and necessity, healthcare CEOs spend much of our time thinking strategically about the overall health and well-being of our organizations. We make yearlong, five- and even 10-year plans. But as healthcare leaders across the United States and globally have faced the tremendous challenges brought about by the COVID-19 pandemic, we have all had to pivot. Today, CEOs are leading day-to-day, sometimes hour-by-hour, amid great uncertainty. Here are lessons learned during this evolving experience.

Think Colleague, Not "Competitor"
Since the COVID-19 crisis began, our organization has actively collaborated with and learned from other health systems in our state, region and beyond. Being located some distance from the New York metro area, we did not receive the same sudden influx of COVID-19 patients as our colleagues in the northern part of the state. This gave us time to adopt social distancing and other safety measures that likely prevented our hospitals from becoming overwhelmed.

Though we are "competitors," the health system leaders in our area view each other as colleagues, and that sentiment carried over into this crisis. A regional health coordinator, appointed by the governor of New Jersey, helped to coordinate obtaining equipment and making plans for patient surges, helping to ensure we had enough available critical care beds.
Especially during a challenge like this pandemic, it is beneficial for CEOs to take a step back, look at the big picture and determine how—collectively as health systems—we can respond to our community's needs.

Focus on Communication
Communication has always been one of the most important skills for CEOs, especially in times of uncertainty. I often refer to the three M's of communication: (1) Leaders should establish themselves as credible messengers whom people trust; (2) they should ensure their message is rooted in truth and best practice, with data to support it; and finally (3) leaders should communicate the messaging in a way that is authentic and easily understood. These attributes are not only important when leading staff but also when interacting with the community.

My organization employed numerous communications vehicles during this crisis. For months, a daily news briefing went to all staff, which often included videos from senior clinical staff members providing important updates on topics such as changes to treatment protocols.

We also created a new variation of our CEO podcast. Over several weeks, I had one-on-one conversations with employees from across the organization—from clinical staff to support teams to call advisers—about their experiences on the front lines.

These discussions, called "Hope in Action," were recorded and distributed—allowing the wider community to meet some of the front-line heroes helping to navigate this health crisis.

Be Visible and Present

During a crisis, it is so important for our front-line workers and the entire organization to know that senior leaders are in this with them. I still do rounds in our EDs and ICUs, and I make sure to listen more than I speak.

Visiting with staff during rounding has helped me better understand the resources and support staff need. It also inspires me. The most common thing I hear from staff members is the pride they feel knowing that their time and talent makes a major difference.

During one podcast episode, an environmental services colleague from one of our EDs talked about how the pandemic has made him realize just how essential his role is to infection control.

Hearing from the health system's heroes like him has helped lift my spirits and motivated me.

Plan for What's Ahead

We must look to the future and make plans that account for both current and future threats.

Many people are practicing medical distancing, putting off needed treatment due to fear of interacting with healthcare facilities. In the months ahead, this could result in influxes of more—and sicker—patients as we attempt to return to a "new normal."

In addition, members of our community face daily challenges, such as food insecurity, lack of transportation and behavioral health issues, many of which have been heightened by the events of 2020.

When we eventually return to whatever new normal awaits, we are still going to be the force that's needed to help this community heal and prosper.

–Adapted from "Hope in Action," Healthcare Executive, by Dennis W. Pullin, FACHE, president/CEO, Virtua Health, Marlton, N.J.

THE UNEXPECTED SIDE EFFECT OF COVID-19: COLLABORATION

With the arrival of COVID-19 came chaos. And from that chaos rose innovations that have transformed healthcare delivery. Yet, according to healthcare executives, during the interim between the arrival of the pandemic and the innovations that followed, a remarkable phenomenon occurred: unprecedented collaboration.

Walls between siloed departments within hospitals tumbled down. Representatives from competing hospitals met to share information. Community organizations and public health departments exchanged data with health systems. Physicians, whose offices had closed, shared their personal protective equipment with colleagues on the front-line of the battle.

Innovation executives participated in roundtable discussions during the virtual HealthLeaders Innovation Exchange this summer to share experiences and ideas with other hospital and health system colleagues. One of the themes to emerge from that discussion was the value of collaboration in the innovation process and the many forms it has taken.

Read more about thee five ways collaboration has helped change the healthcare landscape during the COVID-19 pandemic, along with the advantages this type of cooperation provides to the industry.

–Adapted from "The Unexpected Side Effect of COVID-19: Collaboration," HealthLeaders Media

WELCOME AND CONGRATULATIONS

New Members

OCTOBER

Name	City
Corina B. Clark	
Kay Judge, MD	
Jonathan Miller	Clovis
Kethen So, PharmD, MBA	

NOVEMBER

Name	City
Erin Azevedo, MPH	Pleasant Hill
Lt Col Saunya Bright, MBA, MS	
Qatarina Caringal	Oakland
Philip Cheng, MD	
Sonya Drottar	Santa Cruz
Norah Fakira	
Sean Kinsman	
Carlos De León	San José
Troy R. Logan	Oakland
Harsha Mehta	
Nichole Melvin	
Natasha Oldford	
Laura E. Palmer	
MSgt Zachary Pingree	Fairfield
Nicole Porto	Fremont
Moses Rajan, MBA, MS	Albany
Shane A. Salmeri	Rancho Cordova
Sharnjeet K. Sandhu, DC	Fremont
Antonette Shockey	
Mark A. Tiano	Concord
Bill A. Tracy	
Chantelle Wenz	

DECEMBER

Name	City
ENS Micah S. Avignone	Gilroy
Komal Bains, RPh	Modesto
Amber S. Campbell, DBA, MBA	Sacramento
Jaime Campbell	
LCDR John R. Chandar, Jr.	Turlock
Richard Drew, PharmD	
Anna Graciela B. Frischmon	
Lisa Guidry, MS	
Traci Hunt, MBA, BSN, RN	Chico
Manpreet K. Kang	
Nabeel Khalid	
Adam Khalifa	San Rafael
Jens W. Krombach, MD	San Francisco
Kwamane D. Liddell	Emeryville
Lourdes Moldre	Sacramento
Jordan Newmark, MD	Oakland
Shannon Nueske	
Sean Peterson	San Jose
Reid Rosehill	
Gina A. Ruiz-Brice, MSN, RN	
Constance Wong, MD	

JANUARY

Name	City
Paymon Bagheri	San Francisco
Daniel C. Bel	San Jose
Brandi Cleland	Auburn
Irem Conery, MS	San Jose
Joseph Cunliffe, MHA	Rocklin
Michael Fombang, MD, MHA	San Leandro
Cecile T. Giron	American Canyon
Jesus M. Gonzalez	Bakersfield
Dianna L. Goodwin, MS, RN	Antioch
Chad R. Hickerson	Discovery Bay
Monica Hoyle	Modesto
jacob b. johnson, MS	Walnut Creek
Krystal N. McCarty	Mather
Aileen Naungayan	San Jose
Nicholas E. Nomicos, MD	Chowchilla
Glorinda K. Pastorius, MSN, RN, NEA-BC	Concord
John Ready	Sacramento
Ted Ross	Menlo Park
Lashini Samerawickreme	Oakland
Vinni Schek	Santa Clara
Mark Thomas	Berkeley
Danielle C. Witt	Chico

New Fellows

OCTOBER

Name	City
Col Susan I. Pangelinan, MPA, FACHE	

JANUARY

Name	City
Feras Khoury, JD, FACHE	Livingston

Recertified Fellows

NOVEMBER

Name	City
Arthur D. Villani, FACHE	Bakersfield

DECEMBER

Name	City
John W. Boyd, PsyD, FACHE	Sacramento
Kimberly Joy L. Carney, DNP, RN, FACHE	Sacramento
Lt Col John D. Gillard, FACHE	Mather
Sandhya Jayaraman, FACHE	Santa Clara
Kimberly C. Long, DHA, FACHE	Beal AFT

JANUARY

Name	City
Evelyn S. Colwell-Macklin, FACHE	San Leandro
Mikele B. Epperly, PhD, FACHE	Benicia
Joshua E. Gossett, DNP, RN, FACHE	Palo Alto
Theresa Hamilton-Casalegno, FACHE	Lincoln
Joleen Lonigan, RN, FACHE	Sacramento
Tim Williams, FACHE	Paradise
Michael C. Wiltermood, FACHE	Chico