SHSMD Society for Health Care Strategy & Market Development℠

THE GREAT RETHINK:

CHALLENGING OUR ASSUMPTIONS ABOUT THE FUTURE

REPORT FROM THE SHSMD 2022 **THOUGHT LEADER FORUM**

AHA Data & Insights | *In association with* KaufmanHall

About the Society for Health Care Strategy & Market Development

The Society for Health Care Strategy & Market Development (SHSMD), a professional membership group of the American Hospital Association, is the largest and most prominent voice for health care strategists in planning, marketing, public relations, communications and business development. SHSMD is committed to leading, connecting and serving its members to prepare them for the future with greater knowledge and opportunity as their organizations strive to improve the health of their communities. The society provides a broad and constantly updated array of resources, services, experiences and connections. For more information, visit shsmd.org.

About Kaufman Hall

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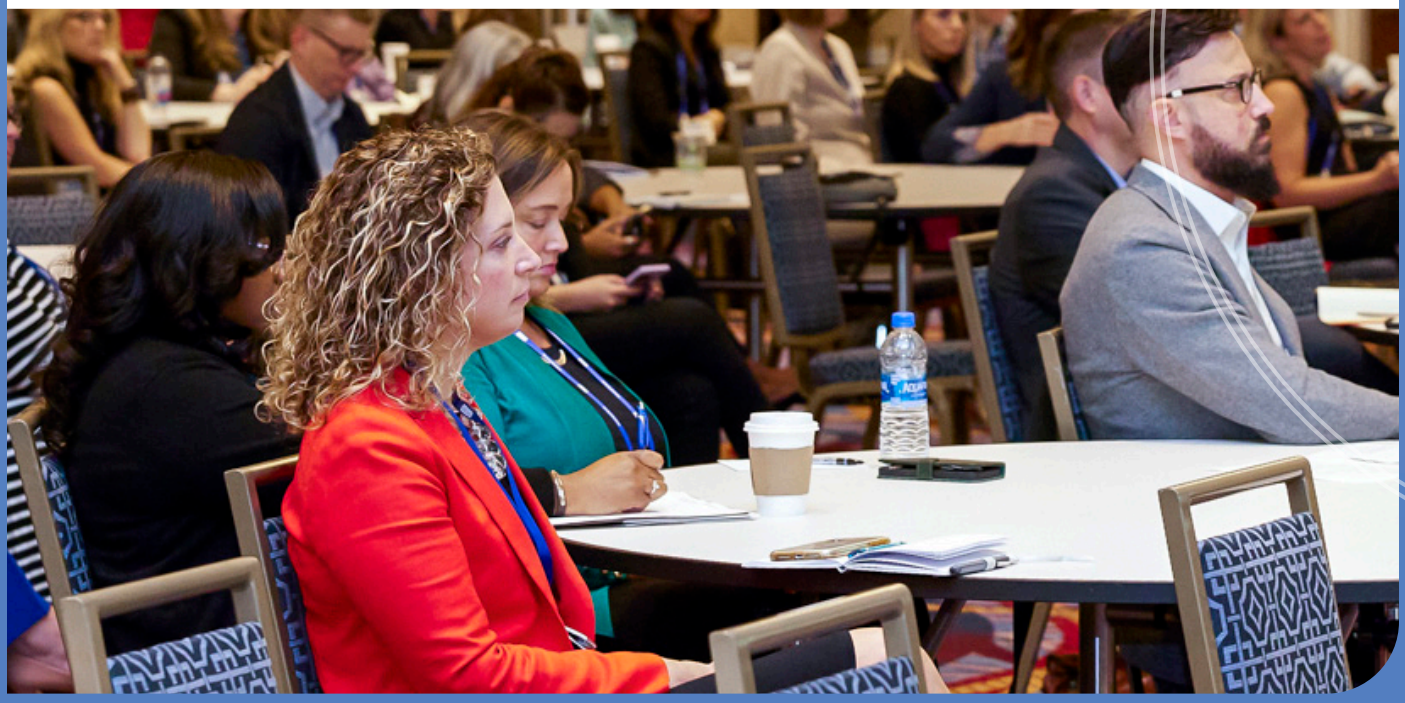

INTRODUCTION

The new skill required of health care leaders today is the ability to drive transformational change optimizing our core businesses while positioning our organizations for big, future-oriented moves. But where do we begin? The 2022 Thought Leader Forum addressed transformational change and how senior leaders are testing assumptions on some core questions to push their organizations forward:

- **What does our service portfolio need to be? What does our community actually need?**
- **How do we truly differentiate our position in the marketplace? How can our brand better communicate our strategic intent?**
- **What is the culture we have today compared to what we want to create? How do we get our talent excited about the future as we manage the present as best we can?**

To help its members think through these questions, the American Hospital Association's Society for Health Care Strategy & Market Development (SHSMD) hosted the forum, "The Great Rethink: Challenging Our Assumptions About the Future," at its 2022 annual conference, SHSMD Connections, in the Washington, D.C., area and available virtually.

Panelists included:

Nicole Harris-Hollingsworth, EdD, MCHES, Vice President, Social Determinants of Health Population Health Administration, Hackensack Meridian Health, Edison, N.J.

Jay Mittal, MHA, Vice President, Service Line Integration, Business Strategy/Development, University of Maryland Capital Region Health, Upper Marlboro, Md.

Gregory M. Wesley, Senior Vice President, Strategic Alliance and Business Development, Medical College of Wisconsin, Milwaukee, Wisc.

The session was moderated by **Ryan Gish,** Managing Director at Kaufman, Hall & Associates, LLC, in Chicago, IL.

Excerpts from the forum follow

EXCERPTS FROM THE FORUM

Hackensack Meridian Health has made a significant commitment to health equity and addressing the social determinants of health. Tell us about your journey and how this became a priority for the organization.

NICOLE HARRIS-HOLLINGSWORTH: As a network, we consolidated in the merger of two major systems about six years ago. So while we are a longstanding organization, we're also a new system needing to come together. As part of that thought process, our board and our leadership teams looked at what data was available, what was coming out of the community health needs assessment, but also what was coming out of our medical schools and what we knew, and needed to know, around the training of physicians and clinical staff. We brought in a consultant because you can't do this without one, but the idea was that we needed to do something related to social needs as a network, not as individual systems. So in February 2020, with great fanfare, we said we are going to start working on the social determinants of health as a network and built it in as a strategic priority. Then of course in March 2020 the entire world changed and everyone's focus adjusted.

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We spent time building infrastructure during that first period of COVID. We were able to secure commitment from both the institution and an assortment of funders to use that time to build infrastructure. What does that mean? Making sure that our electronic health record system worked right and could use a community resource and referral network that made sense. We also made sure to involve the right type of workforce, in our case community health workers, in advancing that work. We became very strategic around identifying key social needs. We looked at anchor social determinants of health, things that no one would argue about. We knew that launching an initiative like this would take several million dollars to do, but could only work with good infrastructure development. And that's what it took—we spent about $4 million and two years to get it done but we were able to get started.

What, if anything, changed in the organization's outlook and assumptions about the future to prioritize these initiatives?

NICOLE HARRIS-HOLLINGSWORTH: It was a matter of looking at the community and the assortment of calls from the community. It wasn't just a summer of justice that got people thinking. It's important to look at the hand you were dealt relative to your state. New Jersey is one of the most diverse

states in the nation. Our hospital network spans just about all of the Eastern Coast of New Jersey, so looking at who was there, what their needs were and how we could challenge the status quo to make a difference, that was what came together and made it happen for us.

There had been frustration coming not only from the communities but also from people working at the hospital: We want to do it right and make a difference; how do we do that? When the network came together, that opportunity motivated everyone and gave people purpose.

Health systems often articulate they "can't be all things to all people." How have you leveraged community partnerships to advance organizational goals?

NICOLE HARRIS-HOLLINGSWORTH: That is very true; we can't be all things to all people, but we do need to better understand what our core strengths are. We are a health care organization and we excel at that, but we are also a large aggregator of services. As we looked at those community partnerships and what they need to be, it became less about us replicating what other community partners were doing and more about identifying how they needed us to engage in the marketplace.

The biggest thing we needed to do was to be able to refer people to community resources. We brought in a business partner because we knew there was strength in their ability to identify community partners, develop a vetting process and have something that could be integrated into our electronic health record in a way that was easily documentable. That was the good-for-us part.

The transparency part, which was really key, was making sure it was good for the community. Can the community access this resource independent of us for free? Yes. Can they do it in all the languages they need to do it in? Absolutely. Could every community partner participate, regardless of our ability to find them? That was a key piece of feedback from the community. They told us, "Hi, large institution, refer to us," and we said, "We're in some ways too large; we have no way of knowing who you are." Having an entity that could bring them in so if I needed to find the food pantry in an obscure zip code, they would know who that was—that was key.

We then needed the right levels of staff members who could relate either geographically, ethnically, or culturally to the community-based organizations that were present. We set up memorandums of understanding and agreements with those organizations so it would be an official relationship. Those things were key.

We brought on big partners and lots of small partners, like behavioral health agencies and food justice and food equity organizations, and everything in between.

We want to be able to say that we, as a network, provided you, the community, with the data to be able to make changes for yourselves. The accessibility of that data to the community is allowing them to seek additional funding to bring in additional resources. That's what I'm most proud of.

Some organizations have had a difficult time measuring impact with these types of initiatives. What has been your approach to performance and metrics?

NICOLE HARRIS-HOLLINGSWORTH: For us, it was important to get a good sense of the data. It was very much all over the place. What are the social needs? Who are we seeing them in? Where are we seeing them? There's what I call the IT side of the argument that was just about our own patients. But what we found to be really important was what the communities we were serving thought about this information. It was a matter of including perception surveys from the community, looking at ongoing health assessments and needs assessments from those organizations, and looking at our ratings among the coalitions we were partnering in. And something we heard very qualitatively was, "You guys are here now more in the ways that we want you here. That's great."

In terms of purely objective metrics, we looked at our utilization data, not only of our own resources, but also of social needs resources in the communities we were working with and those we were trying to engage with. When we referred people to community partners, we asked, "Are they showing up? Are you seeing the uptick to match our referral rate? Are you seeing the uptick in utilization of access to housing services or access to other types of services connected via the United Way in other areas?" We looked at both our internal metrics and the metrics of others to make sure that people were going where we were sending them, and also what the feedback was from others who were sending people to us.

Tell us about the initiative that's made the greatest impact or the one that you're most proud of.

NICOLE HARRIS-HOLLINGSWORTH: We plan on doing a lot of publications in the next year describing our impact. The thing I'm most proud of is that we transitioned inside of a year from a lack of comprehensive screening to a network-wide screening encompassing 18 hospitals and 500-plus community sites on 11 social determinant of health indicators. That includes food, housing, transportation, stress, depression, health care, intimate partner violence, alcohol use and all sorts of quality-of-life issues. That's data we now have that we can share across the state.

In that first year, we went from the occasional random screening to screening over 400,000 individuals, collecting over 1.2 million referrals inside and outside of the organization, and having the detail on these populations to be able to make a difference. We have that data down to the zip code level and we were able to do it transparently. We want to be able to say that we, as a network, provided you, the community, with the data to be able

to make changes for yourselves. The accessibility of that data to the community is allowing them to seek additional funding to bring in additional resources. That's what I'm most proud of.

Greg, we'll turn to you. Give us an overview of the Medical College of Wisconsin and some of the interesting investments your organization is making.

GREGORY WESLEY: The Medical College of Wisconsin (MCW) is the premier private health science university for Milwaukee and the state. We're a private institution with multiple schools, including a school of medicine, a graduate school, and a school of pharmacy. We're a major employer in Milwaukee. We also have regional campuses in Green Bay and Central Wisconsin. We have over 6,000 employees and one of the largest specialty private physician practices in the state. We work closely with Froedtert Health and our pediatric partner is Children's Wisconsin.

One of MCW's major strategic initiatives is called the ThriveOn Collaboration, which is a place-based investment where we are redeveloping a 400,000-square-foot building in the middle of the City of Milwaukee that has been underutilized for many years. We're doing this in partnership with the Greater Milwaukee Foundation, one of the oldest and largest community foundations in the country. We have come together not only to focus on the health system patients but on the community as a whole. We're not just looking at patients who go to Froedtert Health or to Children's; we're looking at the entire city of Milwaukee and saying, "We know what the social indicators are. How can we be an example to others who make investments in a catalytic way?" The foundation is going to move its corporate headquarters to our building, and MCW is moving some of its educational programs, centers, and institutes—some that are currently on campus in Wauwatosa, which is out in the county—into the city. The cancer center, community outreach programs with our office of community engagement, some programs in our center for advancing population science, our comprehensive injury center, and our center for AIDS intervention research, among other things, are being co-located in one location and anchoring a development.

To do this, we are partnering with an urban emerging developer who purchased the building. We took long-term leases, generational leases over 20 years, at market rate for the developer to be able to purchase the building. We are tackling a very tangible example of social determinants of health, for example the housing component. Our long-term leases are catalyzing affordable housing in the building, approximately 89 units that are intergenerational. Twenty-five are for active, mature adults and the rest are for families, one to four bedrooms. We have found community partners for the first floor, with 50,000 square feet of space. We have

a five-star early childhood education provider that will be an exemplar for other early childhood education providers in the area.

We have a health and wellness partner called Versiti, Inc. They're going to bring their employment focus, education focus, and training-focused work to the first floor. We have an economic opportunity with a job provider there as well—Job Work MKE—so it's an exemplar real estate project in the middle of the city that sits at the intersection of three very different neighborhoods and we are the catalytic investment in the area.

You can see changes that are happening in the area based on the work we've done. Some would call it gentrification but it's really in partnership with community members. We have a community advisory council; we engaged community residents at the very beginning of our effort and it's coming together now. We're under construction and we'll occupy the building in January 2024. While we're going through this process, neighborhood residents continue to be involved.

How did you leverage data and analytics to determine in which communities to focus your efforts?

GREGORY WESLEY: With the data, it's easy. You look at the indicators in your community so you know what the health disparities are, what the housing needs are, and what the issues around food deserts are. We knew about all that so we approached it a little bit differently than others might. In our communities, people often cite issues around segregation, food deserts, or education, but few would take the leap and do something comprehensive. They would do it in a siloed way. Many years ago, we had a riot in our city and MCW President John Raymond brought together people who were employed at MCW and people who lived in the area where the riots took place for a listening session. They challenged Dr. Raymond and the institution to do more for the city, and that's what kicked off our work. Instead of just building and saying, "Here's what the metrics are," we said, "What can we do as an institution?" And one of the ideas was the place-based investment. We said we would be committed generationally with our long-term leases and position our centers, our institutes, the community foundation, and others to develop intervention work going forward.

Because we know what the education looks like and we know that the area is a food desert, we decided to go with this underutilized facility and build programs once we start occupying it. You can't hide then because you're right there, you've invested in the community, and the community members are going to hold you accountable. Everybody else will measure you and you'll measure yourself, but you're going to be in the heart of the city when that's taking place.

Tell us about questions you had from board members or others because fundamentally you're an academic institution and you could have chosen not to do this.

GREGORY WESLEY: You can sit in the ivory tower and see everything else around you starting to erode and that doesn't make for a pleasant place. You can't recruit talent; it becomes harder to attract students. And we were seeing that the younger generation expected us to do more. Our board members got it, partially because they understand their role as trustees is really about community impact. Many were saying, "I'm sitting on the board to have an impact on my community. How are we doing that?" They're challenging us to do it in a way that isn't like what they do in their professional roles outside of MCW.

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Looking forward, what do you think the legacy of the project will be?

GREGORY WESLEY: I need to be careful here because I get really excited about it, but I think you'll have multiple white papers out of it. It's a private development with an emerging developer who went out to the private markets to finance the project. It's over $100 million; the challenges of getting that capital were huge. So we'll have a white paper out of that which will change the narrative of urban development and what it should look like. It shouldn't just be one thing; it doesn't have to just be affordable housing.

In our community we have a lot of low income housing tax credit (LIHTC) development, and that tends to migrate to urban and emerging developers, African Americans, Hispanics and others, and all the other private market development with someone else. This is a private development where our developer has been able to attract substantial dollars. That's one area of impact.

I think our centers and institutes will be able to interface with the community in a very different way, so that's another impact. And this is a historic building that will be restored in the heart of a predominantly African American community in a way that has not been done that well in this country. We've looked in Atlanta at purpose-built communities, we've looked on the East Coast with Johns Hopkins, and we've looked in Chicago in the Pullman district area, and I think this project will touch on multiple components of those projects. We have to make it work because we've committed to it for the long term and we have partnered with community residents from the very beginning. It's going to be fantastic and I'm hopeful that it will be an example to others that it's possible. Go in, talk to the community, figure out what they want and then be honest about what you can do and what you can't do.

It's a fantastic example of a public-private partnership.

GREGORY WESLEY: We don't have any public money in it yet. We want the public money to go into the programming work, so we are using our assets first. We'll bring the state, the county, the city, and others in as partners at the programming level. And it's done in a way where we don't have many public money strings attached too early. We have the flexibility to make decisions in pulling it together, so it's a great example, we think.

Jay, let's turn to you. Today we are sitting in Prince George's County, within the service area for your organization. Tell us a little more about the market and history of health care in Prince George's County.

JAY MITTAL: We're part of the University of Maryland Medical System in Prince George's County. Five years ago, in 2017, University of Maryland Medical System acquired a county-run hospital and health care system called Dimensions Healthcare. For decades, the brand and the identity of that county-run hospital was a safety net facility, with three very busy emergency departments spread across the county and a very busy trauma center, the second busiest trauma center in the state. Part of what UMMS was trying to do upon acquisition of this entity was to transform the very identity of this institution. Prince George's County is home to over a million people, yet it lacked a comprehensive, high-quality health care anchor institution and delivery system. UMMS had to figure out how to leverage the fact that we were a critical access hospital, with emergency departments and several assets across the county, in order to rebrand ourselves as not only a high-quality health care anchor institution and delivery system, but also to develop programs of choice.

Five years later, there has been a significant injection of financial capital as well as program building across Prince George's County, to the tune of over $600 million. The focus of that investment is not only to sustain, maintain, and optimize our emergency departments and our trauma program, but also to build centers of excellence for the residents of this community. Unfortunately, community residents have had to leave the county for their health care needs. If you think about a million people needing to leave the county to go into Washington, DC, to go across the bridge into Virginia, or to go to Baltimore or other neighboring counties for health care, that's a big embarrassment. Our goal, again, is to make a concerted effort to provide care and access closer to home for them.

That was a huge decision for the system. How did you challenge assumptions about what was going to be or what

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could be? You had an organization that was failing financially, all that out-migration, referral patterns, physician and self-directed, where people were leaving the county for care. What were those conversations like?

JAY MITTAL: One of our biggest questions was what are the advantages of UMMS coming into this market? Prince George's County has a lot of health care pockets of excellence, private physician practices, and one-off health care system investments in ambulatory infrastructure. But there was nothing fully comprehensive, tying it all together and meeting the needs of the patient population. It was a matter of how we complement the existing talent, that is the private practices and industry partners. How does a rising tide float all boats?

That included things like our medical school partnership in Baltimore. Can we bring a high quality, talented physician community to work here with some of the private-practice primary care doctors or cardiology practices so together we can change how care is being delivered in Prince George's County? The same thing goes with industry partners; there are plenty of folks in the county that have done really good things. How do we become the anchor institution that brings it all together in a much more cohesive, integrated fashion?

You're focusing on some centers of excellence and providing care locally is a key element of that. How did you think about where to focus? There were so many different routes that Dimension/UMMS could take.

JAY MITTAL: As my fellow panelist said, that was easy because the data is very compelling. This county is the second largest one in Maryland, with over a million people, predominantly African American and Hispanic. There's a heavy burden of cardiovascular disease and cancer and a lot of late detection for various disease elements. When it comes to determining what investments our organization is going to make, our CEO likes to ask what problem we are trying to solve for. We also look at the community health report and community feedback. Additionally, we look at, what truly are the needs of the community and what are they seeking? Where do they have to go to fulfill those needs? No surprise, our largest investments are in heart and vascular, cancer services, women's health, and orthopedics and neurosciences. We're building the foundation of what health care should look like in this county.

What are the three of you doing to measure community involvement?

GREGORY WESLEY: When we took our project to the community, we were very careful. We have four missions at MCW: Education, research,

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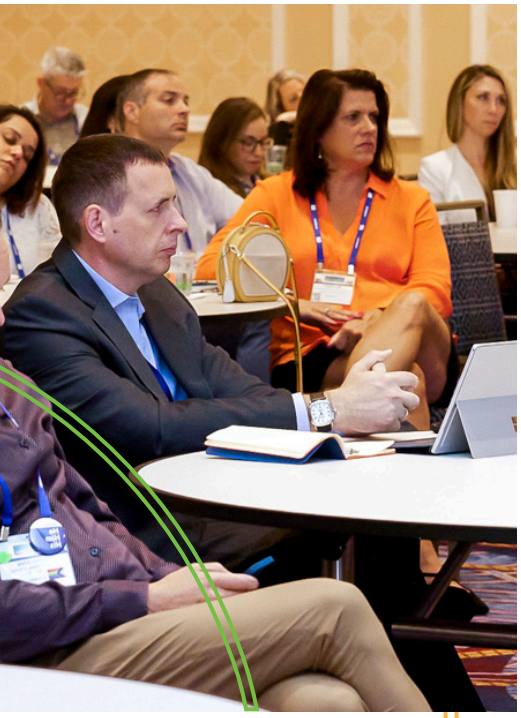
clinical and community engagement. Community engagement is our fourth pillar. We were partnering with our community foundation as well, and they do grants throughout the city, and they were also focusing on equity issues. We created a community advisory council of residents. We didn't just choose them; we worked with them and they chose themselves. We had criteria around representation from each neighborhood that would be impacted, because the building sits at the intersection of three different neighborhoods: Halyard Park, Harambee and Brewer's Hill. Each neighborhood has representatives and there are representatives from MCW, the foundation and other community leaders.

We held multiple discussions about what the needs were and then we repeated back to the community what we heard. We're still developing metrics. We also started to teach them how to evaluate grants. We gave them a pool of dollars that they can grant to smaller community organizations, whether it's for a block party or a community cleanup. And organizations could go to the community advisory council, which evaluates proposals and makes decisions on investments.

We've simplified the way grant proposals work so it's easy for them. A grant writer becomes another part of infrastructure and we didn't think that made sense. We teach them the basics. If it's not simple enough for them to put a proposal together, then we're not doing our job.

NICOLE HARRIS-HOLLINGSWORTH: In terms of how we would ask every patient for information, that was an organizational determination. We did ask for community input about how communities wanted to give feedback. This data was collected and shared with the community on a quarterly basis. Our hospital network covers eight counties with 4.4 million people. People wanted to give feedback in very different ways. In our northern counties, including Bergen and Passaic, they requested to meet as a group of counties. There are community meetings where information is provided, feedback is received and interests are brought up in terms of what the community feels we need to do. They're holding the network accountable for this information and feedback. It's a very bidirectional conversation.

In our central and southern regions, which encompass some slightly more affluent communities, the feedback is directed more to whoever is working with them, related to that hospital, that county and those municipalities. Separately, we also have feedback specifically from our health care organizations, because we say the hospital is a community; the community is the hospital. We ask about community issues and we get all that feedback. We have 36,000 employees and they provide feedback too. We make sure that we are responding to them both as workers in the health care industry but also as residents of the community. We listen to their voice. All of that gets compiled into our community health needs assessments. It's not just a



The social determinants of health space gives us the opportunity for greater collaboration, greater sharing. We have been exceptionally collaborative in this space.

one-time report; it is a living report that is visible very transparently on the Hackensack Meridian Health website so you can see what's happening and what people are saying on a regular basis.

JAY MITTAL: We also have community advisory councils. The residents of the communities we serve have been along with us on this journey for the last several years. We take their input seriously and it's a big part of how we advance decision-making for our care delivery system.

Have you felt any shift? How can you say, "We're making a difference"?

NICOLE HARRIS-HOLLINGSWORTH: I would say it's beginning. One of our challenges is related to the collection of race and ethnicity data. On the technical side, we're attempting to build equity into our system. The core metric is who is coming to our facility. When we started asking that question, as far back as 2020, sometimes we got the data and sometimes we didn't. People weren't necessarily forthcoming. There were a lot of questions: "Why are you asking me this question? What do you mean?" It was our work to do the explaining, to do the education.

We also ask a lot of questions relative to social need. Recently, we've gotten more responses to that question, an easier response, a better response, a more high-quality response. Are we there yet? No, it's not perfect. But we're moving in that direction because our communities are seeing us do the kinds of things they were asking for. A lot of that came out of how we responded to COVID. We responded in a way the community respected, so in turn they engaged more honestly with us.

GREGORY WESLEY: As an academic medical center, the only Level One trauma center in the area, and being outside the city, people were saying it's about time, and they're holding us accountable now. They were cautiously optimistic that we would do what we said we were going to do. We said we didn't have all the answers and we said we would be honest about what we could and could not do. And we would try to inspire others to do very similar things. It's starting to work. There's still a lot of work to do, though.

In many of your markets, you compete with other health systems. What framework exists to bring them into the conversation?

NICOLE HARRIS-HOLLINGSWORTH: I've been with Hackensack for two years. Prior to that I was with Montefiore Health System for 24 years. I remember starting at Hackensack and asking, "How do we share information?" The first answer was, "No one is competing on the social determinants of health. This is the space where we all operate."

We have two primary networks that we're working with. One is the AllSpire Health Partners network. That's really where we come together: What can we cross-learn, not only related to social determinants of health, but other areas where we need to come together? Can we operate in a unified way as a market force to do this? Because we alone can't solve this problem.

We also participate in the Healthcare Anchor Network. The social determinants of health space gives us the opportunity for greater collaboration, greater sharing. We have been exceptionally collaborative in this space, making sure that whatever we do applies one to the other. If I've got great access at Hackensack, I want to make sure that RWJBarnabas Health also has great access because I don't want to be proprietary in this space. We're not yet at the point where we're doing the same thing relevant to some of our other programs but across social needs there is a tremendous amount of collaboration happening.

GREGORY WESLEY: We've tried to create a really big umbrella and we've focused on a part of the city that needs a lot of investment. Other health systems can find ways to partner around us and with others in an area. I think it's going to work because others have been inspired by what we're doing, they're co-locating in the same area and residents are still responding positively. When you have success, others tend to want to be a part of what you're doing and not necessarily compete directly with you.

Where are you with risk-based payments or value-based care?

JAY MITTAL: In Maryland's unique reimbursement model, we're essentially operating in what we call a global budget revenue model, or capitated model. The incentive to grow is actually not there in the hospital setting. The incentive is to keep patients out of the hospital setting and to build robust ambulatory services, prevention, and diagnostics to keep care outside of the four walls of the hospital.

NICOLE HARRIS-HOLLINGSWORTH: We have a value-based care model with partners in place. We've used our engagement with that population to generate opportunities for addressing the needs of our non-value-based care patients. We do have some upside and downside risks that we are managing, but we're progressively moving in that direction.

CONSIDERATIONS FOR STRATEGIC PLANNERS

RYAN GISH: Hospitals and health systems across the country are carving out new roles in addressing social determinants of health and improving health equity. This process necessitates questioning assumptions about the future, leveraging data and analytics to focus organizational efforts and measure impact, and building on community partnerships. The social determinants domain has traditionally been beyond the purview and mission of health care organizations. As hospitals and health systems engage in the "great rethink" associated with this new role, they are gaining a deeper understanding of community needs while striving to meet rising community expectations.

To guide health care leaders in navigating this new terrain, we offer some key considerations from our panelists' discussion.

BE TRANSPARENT. Community trust is a key asset. Be open and honest about what the organization can and cannot do. Expect communities to hold health care organizations accountable for their commitments. Additionally, full transparency about the applications of social determinants information gathered by health care organizations and their business partners is essential.

EMBRACE COLLABORATION. Taking a proprietary approach to the social determinants space defeats the purpose of these initiatives. All stakeholders will benefit by sharing information and working together for the benefit of their communities.

HONOR THE HUMAN ELEMENT. Data is essential for identifying community-specific needs related to social determinants and health inequities. But data is just the starting point. Health care leaders must build relationships with community organizations and representatives to gain a deeper understanding of the people behind the numbers.

SEEK SUSTAINABILITY. Investments in social determinants and health equity are characterized by long payback periods, a strong intangible component and a fundamental incompatibility with conventional fee-for-service payment models. Health care leaders should embark on these initiatives with a clear understanding of their financial ramifications.

PANELIST BIOGRAPHIES

Dr. Nicole Harris-Hollingsworth
Vice President, Social Determinants of Health, Hackensack Meridian Health

DR. NICOLE HARRIS-HOLLINGSWORTH, EDD, MCHES, is a senior health systems scientist and is the Vice President, Social Determinants of Health, for Hackensack Meridian Health in New Jersey. Dr. Harris-Hollingsworth leads the development and implementation of network-wide social determinants of health strategy, stakeholder engagement interventions, and the development of community accessible resources across the Hackensack Meridian Health network. For over two decades she has specialized in the development of community health programs designed to create behavior change and increase knowledge in hard to reach populations including regional school-based programs, national reproductive health organizations and national child welfare organizations. Her interest areas include the development of effective regional collaborations to increase health equity and increasing the use of shared decision-making practices between health care consumers and health care providers to facilitate community-engaged research.

Jay Mittal
Vice President, Service Line Integration, Business Strategy/ Development, University of Maryland Capital Region Health

JAY MITTAL, MHA, is Vice President, Service Line Integration, Business Strategy/Development, University of Maryland Capital Region Health. Mr. Mittal has been with the University of Maryland Medical System for 10 years. He has worked across various UMMS entities over the years. In his current role at UM Capital Region Health, he is focused on the development of an integrated care delivery system across Prince George's County. Prior to transitioning to UM Capital in March of 2019, Mr. Mittal had the opportunity to be part of the System growth, most notably at UM St. Joseph Medical Center. There he worked on the turnaround of that entity. Mr. Mittal completed his undergraduate degree at the University of Michigan, graduate degree at Johns Hopkins, and professional development through executive coaching and further education at the Harvard Business School. As a former teacher with Teach for America, Mr. Mittal maintains his desire to do what is best for the organization and its patients.

Gregory M. Wesley
Senior Vice President,
Strategic Alliances
and Business Development,
Medical College Of Wisconsin

GREGORY M. WESLEY is Senior Vice President, Strategic Alliances and Business Development, Medical College Of Wisconsin (MCW). Since joining MCW in November 2016, Mr. Wesley has acted as a key strategic leader, ambassador and advisor for MCW, and is responsible for ensuring the execution of MCW's strategic initiatives and projects through established and emerging partnerships. Mr. Wesley seeks to nurture, deepen and create relationships with strategic partners, burgeoning enterprises and alliances, and others that support and create opportunities for MCW's long-term growth in Milwaukee, Madison and communities partnered with its regional campuses in Green Bay and Wausau. Mr. Wesley earned his undergraduate degree from Indiana University-Bloomington and his law degree from the University of Wisconsin-Madison.

MODERATOR BIOGRAPHY

Ryan Gish
Managing Director,
Kaufman Hall

RYAN GISH is a Managing Director of Kaufman Hall and a member of the firm's Strategic and Financial Planning practice. Mr. Gish works with executive leadership teams and boards of all types of hospitals and health systems nationwide. The strategic advisory focus is on helping organizations address the most pressing industry challenges through defining and implementing resilient strategies for the changing health care landscape. The result for clients is a platform for their ongoing strategic and financial success.

Mr. Gish has authored numerous articles published in health care professional journals, including hfm magazine, BoardRoom Press, and Trustee. Additionally, Mr. Gish was a contributing author for Health Care Strategy for Uncertain Times, published by AHA Press/Jossey Bass. Mr. Gish is a frequent presenter at national conferences of the American College of Healthcare Executives, The Governance Institute, Healthcare Financial Management Association, and SHSMD. Additionally, he has served as guest faculty at Harvard University, Washington University in St. Louis, and The University of Southern California. He recently completed a three-year term on the SHSMD Board of Directors.

Prior to joining Kaufman Hall, Mr. Gish worked for Jennings Ryan & Kolb and Baxter Healthcare Corporation. Mr. Gish has an MBA with honors from the John M. Olin School of Business at Washington University in St. Louis and a bachelor of science, cum laude, also from Washington University.