We Saw It Coming—What Did We Get Right, and What Did We Miss?

In the time between writing this editorial and its publication, the world will have changed far more than it does in the usual 2-month journal production cycle. The COVID-19 pandemic continues to strain—and in some instances break—our political, economic, and healthcare institutions’ capacities to effectively deal with a crisis. Unfortunately, I do not have anything substantive to add to this audience’s knowledge about COVID-19. Even if I did, it might be woefully out of date or outright wrong by the time you read it, as the situation is evolving rapidly.

Instead, I will look back at how the Journal of Healthcare Management addressed this topic. A little over 13 years ago, in the March/April 2007 issue, Nancy A. Thompson, PhD, LFACHE, and Christopher D. Van Gorder, FACHE, described “a new paradigm for disaster planning” and the role of healthcare executives in preparing us for a pandemic. So, what did they suggest? And what has changed in the intervening period?

On balance, the authors were quite prescient. They shared a chart (Figure 1) to describe how delaying the spread of a flu-like virus (H5N1, or “bird flu,” was the issue then) would give the healthcare system time to prepare for it and the pharmaceutical industry time to develop vaccines. This chart presages the Centers for Disease Control and Prevention’s “flattening the curve” chart that has been widely disseminated to explain the need to engage in social isolation measures such as closing schools and businesses (Figure 2). In particular, the authors focused on the challenges related to the dissemination of accurate information.

Although Thompson and Van Gorder (2007) accurately predicted the need for reliable information, the environment has changed dramatically in the intervening years. The authors called on healthcare leaders to be a primary source of reliable information and to be proactive in reaching out to the media to ensure the epidemic rose to a sufficiently high level of concern in the public consciousness. Two words explain how all that has changed: social media. Now the challenge for healthcare executives is breaking through the “infodemic” of news—some of which is accurate, some of which is dated, and much of which is flat-out wrong. My observation is that hospitals and health systems have, by and large, not been the sources most people in the community turn to for actionable information. We in healthcare should work on that going forward.

Regarding the use of personal safety precautions and personal protective equipment, the authors correctly noted in 2007 that education of the public on these topics would likely be delayed and lead to illnesses and deaths that could have been avoided. What the authors did not fully anticipate was the lack of readiness within the healthcare system that
we are experiencing today. The availability (or rather the absence) of ventilators, N95 respirator masks, and test kits has gained widespread news coverage; however, the long-term care facilities that serve the most vulnerable populations and in which the first major U.S. round of fatalities occurred have received comparatively little attention.

Overall, the piece by Thompson and Van Gorder deserves reconsideration in our current situation. It is worth reading in its entirety in JHM’s online archive (https://journals.lww.com/jhmonline/Citation/2007/03000/Healthcare_Executives__Role_in_Preparing_for_the.5.aspx). Regarding coverage of the topic of pandemic preparation in the intervening years, JHM probably should have done more, and it is far from alone in that respect. With that said, there likely will be no shortage of manuscripts submitted for consideration that dissect and analyze how the healthcare sector has performed in the face of a pandemic.

Despite a pandemic, the world goes on and so shall JHM. This issue features an interview with Charles D. Stokes, FACHE, former president and CEO of Memorial Hermann Health System. Mr. Stokes shares a wealth of insights from his remarkable career. His unrelenting focus on both quality and safety serves as a model for all healthcare leaders. Leading successful efforts to earn the Malcolm Baldrige National Quality Award at two facilities is a particularly high point in his own “high-reliability journey,” as he refers to it.

**FIGURE 1**

*Decreasing and Delaying the Impact of the Gap Through Proactive Education*

![Graph showing the impact of proactive education on pandemic deaths and timing.](image)

*Note.* The curve to the right shows fewer deaths and delayed onset when the public is educated in advance of the pandemic. The curve to the left shows the pandemic death rate and early onset without education and knowledge of preventive measures. *Source.* Adapted from Thompson and Van Gorder (2007).
The Future Leader column by Alison Flynn Gaffney, FACHE, CMRP, takes up the topic of servant leadership. This is one of the two leadership models I often hear hospital managers aspire to (the other being authentic leadership, perhaps a topic for another time), and both are easier said than done. Flynn Gaffney ably describes her efforts and how others might integrate servant leadership into their activities.

In our Financial Challenges column, Paul A. Fogel makes the case for financial professionals to be more collaborative with their clinical colleagues versus taking the typical command-and-control approach—notably in the annual budget drill. Fogel highlights how the need to work across organizations makes collaboration an essential skill for healthcare organizations that want to thrive in a value-based purchasing environment.

The first peer-reviewed research article in this issue is by Jennifer Rivas, RN, FNP-C, who looks at advanced access scheduling. Excessive patient wait times are a major source of dissatisfaction, and patient no-shows can lead to avoidable financial losses. Both problems can be ameliorated using the advanced access scheduling system, and Rivas reviews the literature on that approach in a systematic way.

In a different vein, the article by Danielle N. Atkins, PhD; Meghan Hufstader Gabriel, PhD; Kendall Cortelyou-Ward, PhD; and Timothy Rotarius, PhD, considers how hospitals engage communities regarding social determinants. In my experience at
hospitals, expensive “frequent flyer” patients often came to us in ways that reflected a lack of social support. Addressing social determinants is both good for business and good business.

Next, research by Gwen E. McGhan, PhD; Natalie C. Ludlow, PhD; Cheryl Rathert, PhD; and Deirdre McCaughey, PhD, explores organizational culture and workplace safety. Different healthcare professions appear to have different lenses for viewing the patient safety culture of an organization; as a result, their experiences differ. Creating a shared culture, or at least one where a multicultural environment is respected, is something that needs further study.

Cancer centers are at the apex of our healthcare system in terms of clinical complexity, resources employed, and stakes for patients. These organizations develop idiosyncratic measures to gauge one another, and in the article that concludes this issue, Michael T. Halpern, MD, PhD; Hamlet Gasoyan, DMD; and William E. Aaronson, PhD, explore how those metrics manifest themselves.

Ideally, as a journal editor, I can find some thread and a pithy comment to tie all the pieces of an issue together. Alas, these are trying times, and there are too many things to consider. Certainly, we look forward to providing information that can help healthcare leaders prepare for whatever comes next.

Eric W. Ford, PhD
Editor

REFERENCE